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ABSTRACT

A survey was made of 11 alcohol/drug treatment centers to assess their education services, client treatment, staff inservice, and community/workplace outreach. Background information was gathered on the type of services offered, the organizational operation, licensed bed capacity, physical environment, payment system, and admission criteria. The survey questionnaire was a composite of items extrapolated from the National Drug and Alcohol Treatment Utilization Survey and from survey instruments for alcohol/drug education programs and patient education services. While the investigators examined staff inservice training and community outreach educational efforts, most attention was centered on alcohol/drug education services for the client. No implications were drawn on how much of the treatment plan should be documented separately as education. Results suggested that treatment centers are providing extensive alcohol/drug education services; however, the documentation of such services varied from setting to setting. In most centers, educational activities were directed not only toward the client and staff, but also toward the community and workplace. Recommendations are made for future research on treatment centers. Samples of the survey instruments are appended. (Author/JD)

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ALCOHOL/DRUG EDUCATION SERVICES IN TREATMENT

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Preface

In performing this investigation we were reminded of a quote by Ludwig Wittengenstein, renowned British philosopher from the turn of the century, "Treat the network and not what the network describes." While interested in the treatment of alcohol and drug dependence, we were more interested in the process or network of treatment - especially regarding alcohol/drug education services. It was our intention to assess and not evaluate the kinds of educational services included in treatment programs. During the couse of this study, we were amazed at the extent of educational activities taking place in treatment centers. By the end of the study we were experiencing an astounding and ironic revelation. We, the educational investigators, had become the learners to the instruction and teaching of alcohol/drug treatment professionals.

This was a rewarding undertaking and we would like to acknowledge the following treatment centers for their generous donations of time and effort:

Compcare, CareUnit, operating efficiently out of the Northern Columbia County Community Hospital, for their patience in field-testing the survey questionnaire;

The Lakeland Institute, offering an attractive and effective therapeutic milieu, for their explanation of family involvement in treatment;

Rosary Hall, remaining a traditional centerpiece of treatment efforts, for their description of Alcoholic Anonymous

involvement in recovery;

Interval Brotherhood Home, providing care in a pastoral location, for their exhibition of inspiring care directed toward the indigent;

Edwin Shaw Hospital, displaying an impressively organized treatment approach, for their explication of the need to reach adolescent clientele;

Molly Stark Hospital, working out of a setting rich with archetectual heritage, for their demonstration of measurement of educational services;

Cleveland V.A. Hospital, operating successfully within a huge medical complex, for their making visible the linkages between various excessive behaviors;

St. Thomas Hospital, expanding services to meet the needs of dependent persons, for their willingness to engage in provocative, philosophical discussion;

Cleveland Metropolitan Hospital, offering warm and worthwhile advice in addition to recovery services, for their gracious invitation to participate in treatment (whether we needed it or not) to observe educational techniques;

Glenbeigh - Rock Creek, furnishing personal treatment to clients with a variety of backgrounds, for their interesting emphasis on holistic health in recovery; and

Stella Maris, attending to the high-risk recidivist, for their display of realistic and practical methods of treating the "last chance alcoholic."

We only hope our efforts will benefit you as well as others in the field of alcohol/drug treatment.

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Abstract

The purpose of this investigation was to assess the alcohol and drug education services provided in selected treatment centers. This was accomplished by interviewing program directors and examining educational materials. The survey questionnaire was a composite of items extrapolated from the National Drug and Alcohol Treatment Utilization Survey (NDATUS), and survey instruments for alcohol/drug education programs and patient education services. Results suggest that treatment centers are providing extensive alcohol/drug education services, however, the documentation of such services seemed to vary from setting to setting. Even so, the educational activities were directed not only toward the client and staff, but also toward the community and workplace.

Introduction

Alcohol and drug education services are vital components to a successful treatment program. However, to what extent are these services provided in treatment settings? Attempts have been made to examine the educational materials used in dealing with alcohol and drug problems. For instance, Milgram (1980) investigated alcohol education materials for various audiences which were published from 1973 to 1979. A large portion of these educational productions were designed for counselors, instructors and other professionals. Yet, little seems to have been reported about how much alcohol/drug education is or should be included in treatment programs.

From another perspective, treatment personnel have become more interested in the prevention of alcohol and drug problems (Davis, 1976). If one were to examine the definition of prevention, in terms relevant to alcohol/drug treatment, educational and information services are key elements. For instance, Leukefeld (1982) has cited the definition of prevention according to the National Drug and Alcohol Treatment Utilization Survey:

> . . . referring to the collection and dissemination of knowledge or material relating to alcohol and/or drug abuse. Prevention services offered by units vary widely and may be directed toward any segment of the population. A prevention or information service unit does not provide scheduled, on-going courses. It may, however, maintain a speakers bureau or present a series of lectures. It includes school prevention services, mass media campaigns, and the preparation of brochures (p. 3).

By using this definition Leukefeld was able to report that 55.5 percent of 3,935 surveyed treatment centers provided educational and

prevention services.

Still, it appears necessary to closely examine specific features of alcohol and drug education services in treatment settings. With this in mind, the following survey was conducted.

Purpose of the Study

The purpose of this investigation was to assess the alcohol/drug education services (client treatment, staff inservice, and community/workplace outreach) at selected treatment centers. This was achieved by interviewing directors of such programs and examining sample educational materials.

Procedure

The Centers

Directors of 11 alcohol/drug treatment centers in Northeast Ohio agreed to participate in this survey. In some instances, additional treatment personnel were present during the interview. It should be kept in mind that these centers were self-selected and exhibited a variety of features (see Table 1).

Although queried, directors had difficulty reporting the percentage of total treatment population in their metropolitan area which was being serviced by the center (ten of the 11 directors stated it was less than 25 percent). Also, only four of the centers reported having specialized programs directed toward such groups as youth, women, high-risk relapse clients, and family members.

Table 1

Background Information on Treatment Centers (N=11)

Type of Service		Physical Environment	
alcoholism	6	hospital	8
drug abuse		free standing	2
both	5	other	1
Organizational Operation*		Payment System*	
corporation	1	no fee	1
church-related	1	fixed fee	4
nonprofit	8	sliding-scale	4
hospital district	1	medicare	6
county gov't	3	medicaid	4
state gov't	2	HMO/prepaid	1
federal gov't	1	other	4
Licensed Bed Capacity		Admission Criteria	
range	13-55	specific geographical residence	1
mean	32	parental permission for youth	4
daily vacancy rate	20%	court referrals accepted	3
Other Features			
provision of 24 hour care			10
hotline telephones			8

*Directors could respond to more than one item.

Survey Instrumentation

The Assessment of Alcohol/Drug Education Services questionnaire was developed by extrapolating items from the National Drug and Alcohol Treatment Utilization Survey (Leukefeld, 1982) and survey instruments for alcohol/drug education programs and patient education services (see Appendix A). The questionnaire was examined for appropriateness and adequacy by alcohol/drug specialists in counseling, education and patient services.

Prior to the survey, the questionnaire was field-tested at a treatment center which was not a participant in data collection. Staff at this treatment center examined the questionnaire for readability and comprehensibility.

Data Collection and Analysis

Data were collected during a one and one-half hour interview. Each director was mailed a copy of Assesssment of Alcohol/Drug Education Services one week before the interview. During this time the director was instructed to complete the first section, Background Information, with remaining sections to be filled during the interview. Also, directors were asked to prepare sample materials from their alcohol/drug education services. Once collected, the data were computer analyzed for frequency of response.

Findings

In this section results are presented from data analysis of directors' self report. However, responses to some of the items on the questionnaire did not allow for direct data analysis. Thus, investigators relied on inferences drawn from director responses to these particular items.

Service Provision

Directors were asked to report various services provided in the treatment program (see Table 2). Among the services mentioned, all but one of the centers reported education and eight of the centers stated information services were furnished in treatment. It should be

Table 2

Service Provision at Treatment Centers (N=11)

Individual Therapy and/or Counseling	11
Group Therapy and/or Counseling	11
Family Therapy and/or Counseling	9
Job Counseling and Placement	3
Vocational Rehabilitation and Skill Training	4
Education	10
Psychological Testing	5
Research/Evaluation	4
Outreach	7
Aftercare and Follow-up	10
Child Care	0
Transportation	3
Staff Training	11
Alternatives	6
Referral	11
Information	8
DWI Program	2
Intake and Screening	10
Emergency Care	8
Other Medical Services	10
Early Intervention	4
Employee Assistance Program	2
Self-Help Groups	11
Occupational Alcoholism Program	1

noted that directors were not asked, at this point, to specify if the education or information was directed toward toward alcohol/drug problems per se.

The Treatment Program

Information was gathered on features of the treatment program. Beside the following reported findings which were deduced from data analysis, two other treatment program features were inferred by the investigators. First, less than half of the programs had a patient educator, or patient education expertise, on staff (Item 22). Second, a variety of treatment alternatives are being planned with shorter inpatient and semiresidential programs being more commonly cited (Item 17).

Needs Assessment. Apparently, only six of the centers have conducted a formal needs assessment for their treatment program (see Table 3). Those performing the assessment relied on valuable input from such notable sources as regional councils on alcoholism, Ohio Department of Health - Division on Alcoholism, and the 648 Mental Health Board. When asked about routine needs assessment for clients, the directors reported using a number of sources of information; records, referral reports, staff observations, feedback by clients, and the work of consultants (see Table 4).

Planning Committees. Six of the centers informed the investigators of having community planning committees. Of the centers having these committees, a good mixture of representatives from the community was recorded (see Table 5). However, there seemed to be a lack of individuals from public health and university backgrounds. In regard to the

Table 3

Formal Needs Assessment for Treatment Centers (N=6)

Conferred with:	
Regional council on alcoholism	6
Local drug board	2
Local health department	1
O.D.H. - Division of alcoholism	4
648 Mental health board	3
Other	2

Table 4

Mean Scores on Extent of Routine Needs Assessment for Clients*

Rely on:	
Medical records	4.1
Family records	3.3
Referral agencies	3.1
Clients/residents	4.0
Treatment staff	4.1
Consultants	3.5

*Scoring: (1) not at all, to (5) to a considerable extent

Table 5

Community Planning Committee for Treatment Centers (N=6)

Local business person	2	Parent	1
Medical care person	3	Work manager	2
Laborer	1	Clergy	2
Self-help volunteers	3	Other	4
Elected official	1		

Table 6

Institutional Planning Committee for Treatment Centers (N=9)

Physician	7
Nurse	7
Psychologist	4
Certified counselor	5
Noncertified counselor	5
Administrator	6
A.A.(N.A.) volunteer	3
Social worker	5
Patient educator	1
Clergy	2
Recreation therapist	1
Dietician	1

institutional planning committees, directors disclosed that a variety of administrative and staff members represented these groups (see Table 6).

A.A./N.A. Not to be overlooked was the invaluable assistance of self-help groups in the treatment program. All centers reported either Alcoholics Anonymous or Narcotics Anonymous involvement (in most cases the former was present). The self-help involvement was either sponsor-, self-, agency-, or Big Book-directed (see Table 7).

Treatment Goals and Activities. Directors were requested to report to what extent various activities were provided for achieving five treatment goals (see Table 8). With Problem Delineation, psychological testing seemed to be the least provided activity. Recognition and Acceptance, the second goal, was characterized by the provision of all activities to at least a limited extent. Restoration of Physical Health was supported to some extent by all the suggested activities. The fourth goal of Adaptive Behavior Therapy was marked by all activities provided to some extent. And the last goal, Cognitive Restructuring, was profiled by all activities being provided to some extent.

Table 7

Alcoholics Anonymous (or Narcotics Anonymous) Involvement in Treatment Centers (N=11)*

Sponsor-directed	8
Self-directed	3
Agency-directed	7
Big Book-directed	7

*Directors could respond to more than one item.

Table 8

Mean Scores on Extent of Activities Toward Treatment Goals*

Problem Determination		Adaptive Behavior Therapy	
medical exam	4.9	verbal reinforcement	4.3
blood/urine analysis	4.5	life planning	4.1
drug screening	3.3	adherence to residence rules	5.0
psychological testing	2.7	introduction to A.A.	5.0
Recognition and Acceptance		self-help	5.0
alcohol education	5.0	humanistic/affective activities	4.0
drug education	3.1	spiritual support	4.7
individual counseling	4.5	family involvement	3.7
group counseling	4.9		
Restoration of Physical Health		Cognitive Restructuring	
regular well-balanced meals	5.0	positive staff reinforcement	4.9
instruction on proper diet	4.6	group support	4.9
scheduled exercise/recreation	4.5	reality therapy	4.3
physical fitness instruction	3.1	encounter groups	3.5
scheduled sleep time	5.0		
instruction on resting	4.0		
routine health history	4.9		
body care instruction	3.8		
scheduled stress reduction	3.7		
relaxation instruction	3.4		

*Scoring: (1) not at all, to (5) to a considerable extent.

Policy Statement. One last finding; all surveyed centers considered alcoholism/drug dependence as a disease. However, one of the 11 directors was unable to locate a policy statement to that effect.

Alcohol/Drug Education Services

Information was gathered on features of the treatment centers' alcohol/drug education services. As mentioned in the previous section, likewise, reported findings were deduced from data analysis. However, some of the alcohol/drug education service features were inferred by the investigators. For instance, it was inferred that a majority of centers

recognize the need for alcohol/drug education services yet only seven of the directors could locate a policy statement to that effect (Item 25). In respect to coordinating alcohol/drug education services, a majority of centers appointed a supervisor yet this staff person also handled the management of other treatment services (Item 27). Impressively, a majority of the centers included alcohol/drug education within formal inservice training of the staff (Item 28). Also, eight of the centers incorporated this type of education in portions of the treatment program requiring family involvement (Item 34). Last, only two of the surveyed centers admitted that a written job description was available for staff persons who provided alcohol/drug education services (Item 35).

Needs Assessment. Only five of the 11 treatment centers have conducted a formal needs assessment for their alcohol/drug education services. With those who had, a good variety of informational and educational sources had been contacted (see Table 9).

Institutional Planning Committee. Of the surveyed directors, only three disclosed that an institutional planning committee was present for their alcohol/drug education services. Members on these committees represented most every profession and specialty involved in treatment (see Table 10).

Educational Networking. When queried about correlating or sharing alcohol/drug education services with other treatment services, the directors reported extensive educational networking (see Table 11). For example, it was quite likely that nursing personnel would perform lectures and informative discussions to clients on the nature of alcohol/drug dependence. Outside of the center, all of the treatment centers had set up some kind of formal educational tie with schools, the community or the workplace. For instance, it was quite common for treatment personnel to be invited to schools for talks on the disease concept of alcoholism.

Table 9

Formal Alcohol/Drug Education Needs Assessment for Treatment Centers (N=5)

Conferred with:			
Regional council on alcoholism	5	O.D.H. Div. of alcoholism	3
Local drug board	2	648 Mental health board	2
Public schools	1	University/college	2
Voluntary health agency	2	Consultants	2
Published works	3	Other treatment centers	2

Table 10

Alcohol/Drug Education Institutional Planning Committee for Treatment Centers (N=3)

Physician	2	A.A. (N.A.) volunteer	2
Nurse	3	Social worker	2
Psychologist	3	Patient educator	2
Certified counselor	2	Academic educator	1
Noncertified counselor	1	Clergy	1
Administrator	2		

Alcohol/Drug Education Service Resources. Directors of treatment centers were asked to report what types of internal resources were made available to alcohol/drug education services (see Table 12). Nearly all centers had supplies of such educational resources as books, films, pamphlets, and handouts. In respect to equipment, many if not all the centers made use of various audiovisual projectors and tape players. One exception, however, was the noticeable lack of use of the overhead projector. A number of the centers made sure the staff educators had access to libraries, classrooms, multipurpose rooms, chalkboards, etc... A promising note was that six of the centers have set aside one specific

Table 11

Educational Networking Within and Outside of Treatment Centers (N=11)

Within the Center	
Medicine	9
Nursing	10
Dietetics	10
Psychology	8
Counseling	10
Social Work	6
Spiritual	6
Patient Education	4
Academic Education	4
Community Outreach	4
Outside the Center	
With Schools:	
Consultation care programs	
Training lectures for teachers and administrators on early casefinding	
Educational lectures on alcoholism	
Lifestyle education	
With Community:	
Support for and from Alcoholics Anonymous, Al-Anon and Alateen	
Lectures to Rotary Clubs and other community interest groups	
Alcohol and drug information to jails	
Family forums	
Consultation with other treatment centers	
With Workplace:	
Employee assistance programming	
Lectures and training to work supervisors and key personnel	
Workforce awareness speaking engagements	

room solely for alcohol/drug education instruction. Resources for staff development were apparent. All centers granted release time for staff site visits and conference attendance. Also, all centers provided subsidies for tuition fees if staff chose to enroll in credited courses and workshops. A number of centers furnished monies for periodical subscriptions and the enlistment of consultants in the field.

Table 12

Alcohol/Drug Education Service Resources for Treatment Centers (N=11)

Educational Materials		Facilities	
books	11	library	7
posters	10	classroom for instruction	6
films	11	multipurpose room	11
slides	10	resource center	3
pamphlets	11	chalkboard	11
paper for handout	11	bulletin board	8
tape recordings	11		
		Staff Development	
		release time for site visits	11
Equipment		release time for conference	11
film projector	10	subsidy for tuition fees	11
slide projector	11	subscriptions for periodicals	9
overhead projector	1	subsidy for professional memberships	3
duplicating machine	11	available consultation	7
audiotape player	11		
videotape player	8		

Approaches or Models of Instruction. When the investigators examined the instructional procedure of the alcohol/drug education services, they relied on approaches or models suggested by Engs and Mulhall (1981). It is interesting to note that directors reported applying the abstinence model and the alcoholism approach to a considerable extent and using the social-economic model and alternatives approach hardly at all (see Table 13).

Unit/Lesson/Treatment Plans. While five of the directors reported that unit or lessons plans were used for the instruction of alcohol/drug education, a closer examination by investigators revealed that these basic forms of curriculum were in the context of treatment plans (see Appendix B). Therefore, subsequent inquiry regarding the nature and use of unit or lesson plans had to be modified to terms more relevant to

Table 13

Mean Scores on Extent of Alcohol/Drug Education Model/Approach Application*

Abstinence model (people should not drink or take drugs because of moral, religious, health, or other reasons)	5.0
Social-economic model (irresponsible alcohol and/or drug use should be discouraged because of social and economic reasons)	1.6
Alcoholism approach (alcoholism and/or drug dependence is a disease)	5.0
Alternatives approach (responsible decisions about alcohol and/or drug use result from exposure to alternatives)	2.0

*Scoring: (1) not at all, to (5) to a considerable extent.

treatment plans. Inferences were drawn by the investigators since no direct data collection took place on this portion of the questionnaire (Items 37, 38, and 39). Apparently, goals and objectives are specified in these plans but in the form of a treatment and not an educational process. In most cases, pretesting of clients regarding knowledge, attitudes, and practice took place during admission and screening rather than immediately before instruction. Content, methods and materials were implied and not directly stated in most of these treatment plans. Evaluation, at least in the measurement of knowledge and attitudinal changes, did take place in many of the treatment programs. Further examination of specific features of educational goals and objectives was found to be difficult by the investigators. For example, outcome statements of his sort were not incorporated into the formal treatment plans. However, pretest/screening and post-test/evaluation instruments were made available

to the inquirers (see Appendix B). Examples of treatment plans have been included in the Appendix.

Alcohol/Drug Education Instructional Content. Specific questions were posed to the directors regarding to what extent certain content was included in the alcohol/drug education services (see Table 14). Investigators observed a variety of topics being covered by those providing the instruction. Topics such as effects of alcohol on body, losses from alcohol/drug abuse/dependence, and the disease concept were covered to a considerable extent. Other topics like effects of drugs on the body, the medical role of alcohol/drugs, nature/history of alcohol/drug use, and prevention of problem alcohol/drug use were covered from a limited to some extent. All other topics were hardly covered at all.

Instructional Techniques. When asked about instructional techniques used in alcohol/drug education, directors indicated a good mixture of methods (see Table 15). Besides traditional methods of lecture and readings, the use of media was quite evident. Small and large group discussions were used by all centers. Also recorded were a number of instructional techniques requiring visual or educational aids. However, there seemed to be a discrepancy between the number of centers (1) reporting use of overhead projectors and the number of centers (3) indicating the use of transparencies as an instructional technique.

External Resources. Investigators requested information on the utilization of external resources for alcohol/drug education services (see Table 16). Within the past half year, external sources for alcohol/drug education provision were generally in the forms of A.A. and N.A. volunteerism, services from regional councils on alcoholism and interactional activities with employee assistance programs. Apparently, the centers did not rely

Table 14

Mean Scores on Extent of Content Representation for Alcohol/Drug Education*

Nature and History of Alcohol/Drug Use	3.2
Effects of Alcohol on Body	5.0
Effects of Drugs on Body	4.2
Social Role of Alcohol/Drugs	2.8
Medical Role of Alcohol/Drugs	4.0
Morality and Alcohol/Drug Use	2.0
Alcohol/Drugs and Human Behavior	3.9
Losses from Alcohol/Drug Abuse and Dependence	5.0
Disease Concept	5.0
Alcohol/Drugs and the Law	2.8
Different Treatments for Dependence	2.7
Self-Help Organizations	5.0
Alternatives to Alcohol/Drug Use	3.9
Prevention of Problem Alcohol/Drug Use	3.4

* Scoring: (1) not at all, to (5) to a considerable extent.

too heavily on educational resources from the state or local health departments. In the past year, consistent reliance on A.A./N.A. volunteerism and regional councils was similar to the reporting of low reliance on public health educational resources.

Table 15

Instructional Techniques Used in Treatment Centers (N=11)

Analyzing Media Ads	3	Disclosing Exercises	4
Small Group Discussion	11	Problem Solving	6
Large Group Discussion	11	Value Clarification	6
Bulletin Board/Flip Chart	10	Oral Reports	4
Question Box	1	Learning Games	5
Debates	4	Self-Testing	8
Decision-Making Exercises	7	Films	11
Guest Speakers	11	Video Recordings	10
Lectures	11	Audio Recordings	11
Worksheets	8	Visual Aids	2
Written Reports	7	Role Playing	4
Reading Assignments	11	Survey/Interview Others	3

Table 16

Utilization of External Alcohol/Drug Education Resources for Treatment Centers (N=11)

	past 1/2 yr.	past year
A.A./N.A. volunteers	10	4
Community Intervention Training	4	3
EAP	5	3
ODH - Div. of Alcoholism	2	1
National Council on Alcoholism	3	3
Regional Council on Alcoholism	6	5
Local Drug Board	3	2
Local Health Department	0	1
Federal Clearing Houses	3	6
Professional Literature	1	2

Evaluation. Centers' reports on educational evaluation were similar to information conveyed about pretesting and screening (Items 43-46). Built into the treatment plans were outcome behavioral measurements which took place at the end of inpatient stay or during outpatient programming. These measurements entailed mostly attitudinal and practice changes although one center administered a knowledge assessment (see Appendix B). All centers indicated that evaluation of clients'/patients' learning experience was important to determining the success of treatment. Even so, educational evaluation seemed to be represented more by psychological screening and evaluation than by specifically designed educational assessment tools.

Summary and Discussion

As result of collecting, analyzing and inferring from the data the following has been summarized:

1) Treatment centers in this study exhibited a variety of background features regarding type of service, organizational operation, licensed bed capacity, physical environment, payment system, admission criteria and so forth. While the treatment centers surveyed were self-selected, the investigators believed that reports from their directors were good representations of all treatment centers (having inpatient stay) throughout Northeast Ohio. Also, of the various services provided in these centers, education and information (two important elements of the NDATUS definition of prevention) were quite apparent.

2) In respect to the administration and management of treatment programs, a little more than half of the directors indicated that a

formal needs assessment had been conducted. It should be mentioned that some directors (those operating from hospital settings) did not consider J.C.A.H. as a suitable response to this inquiry. Meaning that, probably most if not all centers have performed a formal needs assessment- if this accreditation is accepted as a qualifying example. This line of reasoning probably holds true with respect to the treatment centers (6) reporting planning committees. A number of centers have formal hospital boards and the directors did not indicate the presence of planning committees.

3) Most of the treatment programs presented by the directors had similar features. Consistent throughout these programs was A.A./N.A. involvement. A closer analysis of treatment goals and related activities yielded some interesting findings. For the most part, educational services are used not only in helping clients recognize and accept their disease but also in assisting clients' physical health restoration. Instruction of proper dieting, fitness, resting, body care and stress management was present to some extent. Of course all treatment programs were heavily laden with therapeutic and self-help activities. And, as previously mentioned, all but one center had documentation on the policy that alcoholism/drug dependence was a disease.

4) Alcohol/drug education services existed in all centers but the provision of these services seemed to be a shared staff responsibility rather than a responsibility designated specifically for an individual or group of staff persons. The trend in conducting a needs assessment or instituting a planning committee for alcohol/drug education services was similar to the reported trend in assessment and planning for the overall treatment programs. Educational networking between centers and

schools, community and workplace was registered by the investigators. Yet many of the educational receprocities between treatment staff and other center staff (medical, nursing, etc.) appeared to be in the form of lecture technique. Anyways, treatment programs are making promising ventures into sharing knowledge of the field with schools, community and employee assistance programs.

5) A variety of alcohol/drug education service features were observed by the investigators. With staff instructors of alcohol/drug education operating out of an abstinence model/alcoholism approach, unit plans were built into treatment plans. More specifically, curriculum construction for the centers' alcohol/drug education unit/lesson plans was a blended portion of the treatment action plan. Therefore, analysis of specific components of the lesson plan (objectives, instructional procedure, etc.) had to be modified or realigned according to the written treatment plan. Still, these treatment plans, in most cases, did not provide investigators with enough information regarding the educational program components: objectives, measurement of entering behaviors, instructional procedure, and evaluation. It should be noted, nevertheless, that the instructional content consisted of a diversity of topics in the alcohol/drug education field. So too, a variety in alcohol/drug education techniques and use of resources was observed by the investigators. Evaluation of educational service success was hampered by the shortage of related measurement instruments. While the centers used various measures for intake, screening, program performance and discharge, few of the examined instruments seemed to be constructed for measuring changes from precisely designed, client learning experiences (i.e. what they learned from certain lectures or discussions).

Examination of Sample Educational Materials

This section discusses sample facets or components of alcohol/drug education programming for clients in treatment. These materials represent examples of educational portions of treatment planning as furnished by directors of centers. Please keep in mind that the following are merely examples of educational treatment planning and do not necessarily exemplify successful treatment. While most treatment directors submitted sample educational materials, the investigators selected certain examples which clearly demonstrate components of educational treatment planning.

Educational Program Outline

CareUnit/CompCare at Northern Columbiana County Community Hospital submitted a basic outline of the educational portion of treatment (see Appendix B1). This outline contains an ordered list of sessions comprised of lectures and exercises. Also found in the Care Program Manual (not included in this report) were additional well-documented components of alcohol/drug education instruction in treatment.

Therapeutic Education

Serenity Hall of St. John and West Shore Hospital provided good examples of therapeutic education in which designers specified the problem, goals, objectives, format, and evaluation (see Appendix B2). In so much as the action plans centered on therapeutic activity, some portions of the plans reflected educational efforts. This center also submitted activity sheets in stress management and working the personhood system.

Pretesting

Offered by the Cleveland V.A. Hospital were good samples of educational pretesting (see Appendix B3). Worksheets are presented to the clients prior to educational treatment which deal with a number of topics related to personal and social growth. The materials are designed as self-examination exercises, regarding steps and plans in obtaining education, improving relationships with community, and activating old/developing new interest, etc. Information provided on these worksheets is used to insure appropriate care for the client.

Molly Stark Hospital also offered some measurement tools for pre- and post-testing (see Appendix B4). An Alcoholism Quiz (cognitive scale) and a Self-Evaluation Scale (affective scale) are administered to assess the clients' needs (knowledge and attitudes) prior to the treatment program. These instrument are also administered at the end of inpatient stay with comparisons between pre- and post-test scores used for treatment program evaluation. Also, note how tests correspond to treatment goals.

Instructional/Therapeutic Procedure

The Lakeland Institute furnished a Resident Educational Manual for helping the client understand the illness of alcoholism and chemical dependency (see Appendix B5). Good sample materials which depicted the instructional/therapeutic procedure were: The Feeling Chart (knowledge), Johari Window (affective), Exercise Time (practice). In addition to all the well-devised activities in this Educational Manual is the inclusion of homework assignments.

Cleveland Metropolitan Hospital also submitted a noteworthy instructional/therapeutic activity sheet which questions clients on personal

relevancy of A.A., understanding of a dry drunk, and estimation of remaining sober (see Appendix B6).

Interval Brotherhood Home presented a list of educational resources utilized in their treatment program (see Appendix B7). A number of textbooks, pamphlets, journals and films are located on this list.

Evaluation

Many of the centers relied on evaluation instruments which assess treatment effect and not just client learning changes. An exception, however, were the evaluation scales developed at Molly Stark (see Appendix B4). Another previously cited center, The Lakeland Institute, submitted a Patient Evaluation Form (enclosed in the Resident Educational Manual) which asked clients to their impressions of the educational and therapeutic components of the program (see Appendix B8).

Rosary Hall provided an attitudinal assessment instrument directed toward the spouses of dependent persons in treatment (see Appendix B9). This instrument could be used for both pre- and post-testing clients' spouses to ascertain the status of family involvement in treatment.

Conclusions and Recommendations

The results of this investigation can be reduced to two basic conclusions:

1) Alcohol/treatment centers of Northeast Ohio exhibit many similar treatment program features. Whereas some of the treatment programs have specific foci (i.e. family approach, care for the indigent, heavy A.A. involvement), by and large, all of these treatment approaches are well-planned and comprehensive in nature.

2) Regarding alcohol/drug education services, evidence has been obtained supporting the claim that these kinds of activities are in abundance in treatment programs. Treatment personnel who provide these educational services rely on the expertise of other professionals at times, as well as furnishing their educational expertness outside the center. Within the alcohol/drug education instruction to clients, a number of topics are covered; a variety of method/techniques are used; and an assortment of resources are utilized. However, needs assessments and planning committees have not been fully conducted or developed for these educational services. Also, most centers lack designation of a specific staff person as director of alcohol/drug education services (assigning this responsibility, rather, to team treatment groups). In examining sample educational materials, the documentation of educational treatment curricula seemed to vary considerably. While nearly all centers implemented alcohol/drug education lessons out of treatment plans, only a few centers could exhibit specific features or components of the educational treatment: goals/objectives, measurement of entering behaviors, instructional procedure (cognitive, affective and practice), and

evaluation. Even fewer centers documented what type of instructional technique or resource should be used in conveying the content to clients. Also, evaluation of changes in clients' alcohol/drug knowledge, attitudes, and practices (or intentions to practice) seemed to be inconsistently conducted throughout the sample of surveyed centers. While some of the directors reported the use of specific measurement tools (i.e. an alcoholism quiz), for the purpose of evaluation, a number of the directors relied on overall treatment evaluation as an indication of education service effect on clients.

Before recommendations are provided to future investigators, some points should be made clear. As a reminder of the purpose of this survey, the investigators attempted to assess and not evaluate the extent of alcohol/drug education services in nearby treatment centers. While the investigators examined staff inservice training and community outreach educational efforts, most attention was centered on alcohol/drug education services for the client. The investigators have not tried to imply in what capacity the education should be a part of treatment (e.g. how much of the treatment plan should be documented separately as education). Rather, the investigators have tried merely to understand how education is presently used within the treatment process. Future researchers/ evaluators of alcohol/drug education services in treatment centers may want to incorporate the following recommendations into their investigative work:

1) The survey questionnaire should be shorter in length than the one used in this study. While the investigators were ambitious in collecting a large amount of information on the treatment program and respective educational services, an unnecessary number of questionnaire

items were posed to the center directors. It was felt by the investigators that the excessive number of questions burdened the interviewing sessions at times. If the questionnaire was shortened, possibly, there could have been better use of time in examining educational services (e.g. more time to tour the center).

2) The survey questionnaire should be written in terms more familiar to treatment personnel. Even though the questionnaire was field-tested at a separate treatment center (and examiners at this setting forecasted possible communication difficulties) the investigators included too much educational jargon and this may have jeopardized data collection and measurement. For instance, it is not necessary to ask questions about specific types of educational objectives when most outcome statements submitted by directors were clearly written in terms relevant to treatment objectives.

3) The sample educational materials were very useful to the investigators. Therefore, it is important for future investigators to insure that treatment directors have these sample materials available at the time of the interview. During the course of this survey, the investigators neglected to remind the directors about submitting the materials and thus, some samples did not reach the investigator until after the survey. The investigators believed they would have better understood educational service provision if the materials were on hand during the interview.

4) Observation of educational service provision would have been a fine complement to data collection and examination of sample educational materials. The investigators suggest that future inquirers should set up appointments with treatment directors so as to observe lectures, group

discussions and film showings during the treatment process.

5) Future investigators, especially those interested in evaluating the alcohol/drug education services at treatment centers, should remember the importance of including treatment personnel in the planning and actuating of the investigative work. In this study, the investigators relied on input from treatment personnel for the development of the questionnaire. More input should have been solicited regarding how best to conduct the survey - the right kinds of things one should look for. Meaning that, some of the limitations to this investigation (i.e. lengthy questionnaire, inappropriate survey terminology, negligence in obtaining sample materials and lack of true observance of educational treatment) could have been avoided if the additional treatment experience was assimilated into the preparatory stage of this survey.

APPENDIX A

ASSESSMENT OF ALCOHOL/DRUG EDUCATION SERVICES

Center _____ Executive Director _____

Address _____ Director of Education _____

_____

Telephone _____ Interviewee _____

The purpose of this survey is to collect information regarding the educational services that are made available to your residents/clients. Before this information can be compiled it is necessary to confirm your status as either a prevention or a nonprevention treatment facility. According to the National Drug/Alcohol Treatment Utilization Survey (Department of Health and Human Services), prevention is defined as: referring to the collection and dissemination of knowledge or material relating to alcohol and/or drug abuse. Prevention services offered by facilities vary widely and may be directed toward any segment of the population. A prevention or information service of a facility does not provide scheduled, on-going courses. It may, however, maintain a speakers bureau or present a series of lectures. It includes school and community prevention services, mass media campaigns, and the preparation of brochures.

Do you meet this description of a prevention treatment facility? ___ Yes ___ No

If no, explain _____

_____

_____

Background Information

1. What is the orientation of your center?

___ alcoholism services ___ drug abuse sercices ___ alcoholism & drug abuse services

2. Which of the following best describes this center's physical environment?

___ hospital Other _____

___ mental health center _____

___ free standing center

___ government supported center

3. In percentages, please describe the residence of the population served by this center.

____ inner city ____ suburban
____ other urban ____ rural

4. Which of the following organizations is legally responsible for the operation of this center?

For Profit	Nonprofit	State-Local Government	Federal Government
____ individual	____ church related	____ state	____ U.S. Public Hlth. Service
____ partnership	____ nonprofit organization	____ county	____ Armed Services
	____ other nonprofit	____ city	____ V.A.
		____ city/county	____ other federal agency
		____ hospital district	
		____ other substate gov't	

5. Does your center provide 24 hour care?

____ yes If yes, enter the licensed bed capacity ____
____ no

6. What is the average length of stay in treatment at your center? ____

7. What is the average daily vacancy rate at your center? ____

8. Which of the following services are provided directly at your center?

____ individual therapy and/or counseling
____ group therapy and/or counseling
____ family therapy and/or counseling
____ job counseling and placement
____ vocational rehab. and skill training
____ education
____ psychology testing
____ research/evaluation
____ outreach
____ aftercare and follow-up
____ child care
____ transportation
____ other _____

____ staff training
____ alternatives (divergent programs)
____ referral (to other facilities)
____ information
____ DWI program
____ intake and screening
____ emergency care
____ other medical services
____ early intervention
____ employee assistance program
____ self-help groups available
____ occupational alcoholism program
____ other _____

9. Which of the following population groups are provided specialized programs at your center?

____ blacks ____ youth ____ not applicable
____ hispanics ____ elderly ____ other _____

10. Which of the following payment systems best applies to your center?

____ no fee ____ medicare accepted ____ other _____
____ fixed fee ____ medicaid accepted
____ sliding-scale fee ____ HMO/prepaid

11. Which of the following best describes the admission critia at your center?

____ clients reside in a specified geographic area
____ clients must be detoxified prior to admission
____ clients must be referred by a physician
____ parental permission is required for youth
____ court referrals are accepted
____ none of the above

12. If your unit is not open 24 hours/day, kindly submit the hours of operation.

Mon. _____ Thur. _____ Sat. _____
Tues. _____ Fri. _____ Sun. _____
Wed. _____

13. Does your center have a hotline?

____ yes If yes, the telephone number is _____
____ no

The Treatment Program

14. Has your center conducted a needs assessment for alcohol and/or drug dependence treatment in your county or service area?

____ Yes ____ No

If yes, which of the following have you conferred with:

____ a regional council on alcoholism ____ O.D.M. - Division of Alcoholism
____ a local drug board ____ 648 Board
____ NCA affiliate ____ Hospital Administration Association
____ local health department ____ other _____

15. Approximately how much of the total treatment population in your county or service area is being met by your center?

____ 0-25% ____ 51-75%
____ 25-50% ____ 76-100%

To a considerable extent (5)
To some extent (4)
To a limited extent (3)
Hardly at all (2)
Not at all (1)
N/A (0)

16. Is there a routine needs assessment for the clients/residents within your center?

____ Yes ____ No

If yes, to what extent do you rely on information from:

a. medical records 0 1 2 3 4 5
b. family records 0 1 2 3 4 5
c. referral agencies 0 1 2 3 4 5
d. clients/residents 0 1 2 3 4 5
e. treatment staff 0 1 2 3 4 5
f. consultants 0 1 2 3 4 5
g. other _____ 0 1 2 3 4 5

17. For future planning purposes, have treatment alternatives been considered for your center?

____ Yes ____ No

If yes, to what extent have you considered the following:

a. inpatient only 0 1 2 3 4 5
b. outpatient only 0 1 2 3 4 5
c. shorter inpatient 0 1 2 3 4 5
d. shorter outpatient 0 1 2 3 4 5
e. longer inpatient 0 1 2 3 4 5
f. longer outpatient 0 1 2 3 4 5
g. semiresidential - day clinic 0 1 2 3 4 5
h. semiresidential - evening clinic 0 1 2 3 4 5
i. semiresidential - weekend clinic 0 1 2 3 4 5
j. other _____ 0 1 2 3 4 5

18. Is there a community planning committee for your center?

____ Yes ____ No If yes, who chairs it? _____

Which of the following represent this planning committee?

____ public health official
____ public school educator or administrator
____ local business person
____ community agency person
____ medical care person
____ student
____ laborer
____ self-help volunteer (A.A., N.A., etc.)
____ elected official (judge)
____ parent
____ supervisor or manager
____ university professor
____ ministry or priesthood
____ other _____
____ other _____

19. Is there an institutional planning committee for your center?

____ Yes ____ No If yes, who chairs it? _____

Which of the following represent this institutional planning committee?

____ physician
____ nurse
____ psychologist
____ certified counselor
____ noncertified counselor
____ administrator
____ A.A. (or N.A.) volunteer
____ social worker
____ patient educator
____ academic educator (staff)
____ minister
____ other _____

20. Does either planning committee consider alcoholism and/or drug dependence a disease?

____ Yes ____ No

If yes, has this position statement been included in a written policy?

____ Yes ____ No If yes, could you supply a description or copy of this statement:

_____

_____

_____

21. Is there A.A. (or N.A.) involvement in your treatment process?

____ Yes ____ No

If yes, which of the following best describes this involvement

____ sponsored-directed ____ agency-directed
____ self-directed ____ Big Book-directed

22. Is there a patient educator on your staff?

____ Yes ____ No If yes, please describe this position _____

_____

_____

23. Of the following goals in alcohol and/or drug treatment, kindly determine to what extent you provide activities to meet these goals:

To a considerable extent (5)
To some extent (4)
To a limited extent (3)
Hardly at all (2)
Not at all (1)
N/A (0)

A. Problem Identification

1. Determination of problem

- medical examination 0 1 2 3 4 5
- blood/urine analysis 0 1 2 3 4 5
- drug screening 0 1 2 3 4 5
- psychological testing 0 1 2 3 4 5
- other _____ 0 1 2 3 4 5

To a considerable extent (5)
To some extent (4)
To a limited extent (3)
Hardly at all (2)
Not at all (1)
N/A (0)

2. Recognition and acceptance
   - alcohol education 0 1 2 3 4 5
   - drug education 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5
3. Self-assessment
   - individual counseling 0 1 2 3 4 5
   - group counseling 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5

B. Restoration of Physical Health
1. Nutrition
   - regular well-balanced meals 0 1 2 3 4 5
   - instruction on proper eating habits 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5
2. Exercise
   - regularly scheduled exercise/recreation 0 1 2 3 4 5
   - instruction on physical fitness 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5
3. Rest
   - scheduled adequate sleep time 0 1 2 3 4 5
   - instruction on resting and proper sleep 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5
4. Personal Hygiene
   - routine health history 0 1 2 3 4 5
   - instruction on care of body 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5
5. Stress Management
   - scheduled time for stress reduction 0 1 2 3 4 5
   - instruction on relaxation exercises 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5

C. Behavioral Modification (Therapy)
1. Adaptive behavior (including acceptable work behavior)
   - verbal reinforcement 0 1 2 3 4 5
   - life planning (at least day-to-day) 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5
2. Establish/Maintain Sobriety (Abstinence)
   - adherance to rules during residency..... 0 1 2 3 4 5
   - introduction to A.A. (N.A.) 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5

To a considerable extent (5)
To some extent (4)
To a limited extent (3)
Hardly at all (2)
Not at all (1)
N/A (0)

3. Improved Social and Communication Skills
   - self-help groups 0 1 2 3 4 5
   - humanistic and affective activities 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5
4. Inner Direction (Faith) - Not External Direction
   - spiritual support 0 1 2 3 4 5
   - family involvement 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5

D. Cognitive Restructuring
1. Self-Esteem (Confidence)
   - positive reinforcement by staff 0 1 2 3 4 5
   - group support 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5
2. Perception of Control of Choice
   - reality therapy 0 1 2 3 4 5
   - encounter groups (counteract manipulation) 0 1 2 3 4 5
   - other _____ 0 1 2 3 4 5

Alcohol and Drug Education Services

24. Has a needs assessment been conducted for the alcohol and/or drug education services at your center?

____ Yes ____ No

If yes, which of the following sources of educational specialists have been conferred with

____ a regional council on alcoholism
____ a local drug board
____ public schools
____ voluntary health agencies
____ published works
____ O.D.M. - Division of Alcoholism
____ 645 Board
____ university
____ private corporations - consultant
____ other treatment centers _____
____ other _____

25. Does your institutional planning committee recognize the need for alcohol and/or drug education in the treatment process?

____ Yes ____ No

If yes, has this position statement been included in a written policy?

____ Yes ____ No If yes, could you supply a description or copy of this statement:

_____

_____

_____

26. Is there an institutional planning committee for your alcohol and/or drug education services?

____ Yes ____ No If yes, who chairs it? _____

Which of the following represent this planning committee?

____ physician
____ nurse
____ psychologist
____ certified counselor
____ noncertified counselor
____ administrator
____ A.A. (or N.A.) volunteer
____ social worker
____ patient educator
____ academic educator
____ minister
____ other _____

27. Is there a coordinator of the alcohol and/or drug education services at your center?

____ Yes ____ No

If yes, who is this person (degrees, certificates, etc.) _____

_____

Briefly describe professional work experience _____

_____

28. Do the staff members of your center receive any inservice training in alcohol and/or drug education?

____ Yes ____ No

If yes, who provides this training? _____

Kindly describe this training: _____

_____

29. Have formal and professional relationships been established between your alcohol and/or drug education services and similar services provided by the schools, community, and the workplace?

____ Yes ____ No

If yes, please described these relationships. For instance, was expertise shared? Have you provided any service to them? Have they reciprocated?

Schools _____

_____

_____

Community _____

_____

_____

_____

Workplace _____

_____

30. Is there a separate budget for the alcohol and/or drug education services at your center?

____ Yes ____ No

If yes please give a breakdown:

a. Educational Materials ..... ____%

____ books _____

____ posters _____

____ films _____

____ slides _____

____ pamphlets _____

____ paper for handouts _____

____ tape recordings _____

____ other _____

b. Equipment ..... ____%

____ film projector ____ duplicating machines

____ slide projector ____ audio tape player

____ overhead projector ____ video tape player

____ opaque projector ____ other _____

c. Facilities ..... ____%

____ library

____ separate classroom for instruction

____ multipurpose room

____ resource center

____ chalkboard

____ bulletin boards

____ other _____

d. Staff Development ..... ____%

____ release time for site visits _____

____ release time for conferences _____

____ subsidy for tuition fees _____

____ available subscriptions for periodicals _____

_____

____ subsidy for professional organizations memberships _____

_____

____ available consultation _____

____ other _____

31. Are the alcohol and/or drug education services merged or integrated with other services at your center?

____ Yes ____ No

If yes, indicate how any of the following services are merged with the alcohol and/or drug education services at your center:

____ medical _____

____ nursing _____

____ other health care (dietician) _____

____ psychological _____

____ counseling _____

____ social work _____

____ spiritual _____

____ patient education _____

____ academic education _____

____ community outreach _____

____ other _____

32. Do the providers of your alcohol and/or drug education services consider their work to be preventative in nature?

____ Yes ____ No Please comment _____

_____

_____

33. Do the providers of your alcohol and/or drug education services consider therapeutic techniques (i.e. behavioral modification, improved communication skills, cognitive restructuring) to be useful in their effort to educate?

____ Yes ____ No Please comment _____

_____

_____

34. Is the family involved in your alcohol and/or drug education services?

____ Yes ____ No. If yes, please explain _____

_____

_____

35. Is there a job description for the staff person(s) who provide alcohol and/or drug education services at your center?

____ Yes ____ No

If yes, is this description in written form?

____ Yes ____ No If yes, is a copy available? If no, please answer the following:

What are the requirements for this position? _____

_____

_____

What are the responsibilities of this position?_____

_____

_____

36. To what extent are the following approaches/models used in the provision of alcohol and/or drug education services:

To a considerable extent (5)
To some extent (4)
To a limited extent (3)
Hardly at all (2)
Not at all (1)
N/A (0)

a. abstinence model (people should not drink or take drugs because of moral, religious, health, or other reasons)	0	1	2	3	4	5
b. social-economic model (irresponsible alcohol and/or drug use should be discouraged because of social and economic reasons)	0	1	2	3	4	5
c. alcoholism approach (alcoholism and/or drug dependence is a disease)	0	1	2	3	4	5
d. alternatives approach (responsible decisions about alcohol and/or drug use results from exposure to alternatives)	0	1	2	3	4	5
e. other _____	0	1	2	3	4	5

37. In regard to your alcohol and/or drug education services, are unit or lesson plans available for perusal?

____ Yes ____ No

If yes, do these plans contain the following:

____ goals/objectives

____ pretests for assessing clients/residents entering behaviors (knowledge, attitudes, and practices)

____ content for the instructional procedure

____ methods/techniques for the instructional procedure

____ available resources for the instructional procedure

____ evaluation (post-tests for knowledge, attitudes, and practices)

38. Which of the following best describes the goals/objectives in these unit or lesson plans:

____ written by the planning committee

____ written by the director of alcohol and/or drug education services

____ written by the patient educator

____ written by the provider(s) of alcohol and/or drug education

____ written as process goals/objectives (what the client/resident will be able to do during the unit or lesson plan)

____ written as performance goals/objectives (what the client/resident will be able to do at the end of the unit or lesson plan)

____ written as behavioral goals/objectives (what the client/resident will be able to do, under certain circumstances, to a certain degree of proficiency)

____ written in the cognitive (knowledge) area of learning

____ written in the affective (attitudes) area of learning

____ written in the psychomotor (practice) area of learning

39. Indicate if and how the clients/residents are pretested in the following areas of learning prior to the instructional procedure.

a. cognitive (knowledge of the effects, etc.)

____ Yes ____ No If yes, how? _____

_____

b. affective (feelings and attitudes toward use)

____ Yes ____ No If yes, how? _____

c. practice (actual use prior to admittance)

____ Yes ____ No If yes, how? _____

40. To what extent do each of the following represent the content of instruction in your alcohol and/or drug education services?

To a considerable extent (5)
To some extent (4)
To a limited extent (3)
Hardly at all (2)
Not at all (1)
N/A (0)

a. the nature and history of alcohol/drug use	0	1	2	3	4	5
b. the effects of alcohol on the body	0	1	2	3	4	5
c. the effects of drugs on the body	0	1	2	3	4	5
d. the social role of alcohol/drugs	0	1	2	3	4	5
e. the medical role of alcohol/drugs	0	1	2	3	4	5
f. morality and alcohol/drug use	0	1	2	3	4	5
g. alcohol/drugs and human behavior	0	1	2	3	4	5
h. losses from alcohol/drug abuse and dependence	0	1	2	3	4	5
i. the disease concept of alcoholism and drug dependence	0	1	2	3	4	5
j. alcohol/drugs and the law	0	1	2	3	4	5
k. various treatments for alcoholism and/or drug dependence	0	1	2	3	4	5
l. self-help organizations such as A.A. and N.A.	0	1	2	3	4	5
m. alternatives to alcohol and/or drug use	0	1	2	3	4	5
n. prevention of problem drinking or drug use	0	1	2	3	4	5
o. other _____	0	1	2	3	4	5

41. Which of the following instructional techniques are used in the instruction of alcohol and/or drug education at your center? (check mark) Which of these techniques can be use specifically for prevention purposes? (P)

____ analyzing media advertisements
____ small group discussions
____ large group discussions
____ bulletin boards and flip charts
____ question box
____ debates
____ decison-making exercises
____ guest speakers
____ lecture
____ worksheets
____ written reports
____ reading assignments
____ surveying/interviewing others
____ disclosure exercises
____ problem solving exercises
____ value clarification exercises
____ oral reports
____ learning games
____ self-testing/self-examination
____ films
____ video recordings
____ audio recordings
____ visual aids such as transparencies
____ role playing and dramatization
____ student project demonstration
____ other _____

42. Which of the following resources have been used in the instruction of alcohol/drug education at your center?

Past 6 Mo.	Past Year	
____	____	A.A./N.A. volunteers _____
____	____	Community Intervention _____
____	____	EAPs _____
____	____	O.D.M. - Div. of Al. _____
____	____	NCA _____
____	____	local public hlth. dept. _____
____	____	local drug board _____
____	____	regional coun. on al. _____
____	____	federal clearinghouses _____
____	____	other _____
____	____	other _____

43. Indicate if and how the clients/residents are post-tested in the following areas of learning after exposure to the instructional procedure.

a. cognitive (knowledge of the effects, etc.)

____ Yes ____ No If yes, how? _____

b. affective (feelings and attitudes)

____ Yes ____ No If yes, how? _____

c. practice (use or intention to use)

____ Yes ____ No If yes, how? _____

44. Are records kept of clients/residents' progress and performace in alcohol and/or drug education?

____ Yes ____ No If yes, who keeps the records? _____

45. Are these educational records used in tandem with other records to assess clients'/residents' progress and "success" in treatment?

____ Yes ____ No If yes, in what way(s)? _____

_____

_____

46. Are these education records used to upgrade and modify the alcohol and/or drug education services at your center?

____ Yes ____ No If yes, in what way(s)? _____

_____

_____

_____

_____

APPENDIX B1

TABLE OF CONTENTS

Forward:	Recommendations for Utilization of Core Program	
	LECTURES:	EXERCISES:
Session 1:	The Disease: Alcoholism and Other Chemical Dependencies (Part I & II)	Personalized Disease Chart
Session 2:	Sobriety: Its Many Faces	(A) Positive Me Exercises (B) Letters
Session 3:	The Deadly and Deceptive D's	(A) Twenty Questions (B) Deadly and Deceptive D Worksheet
Session 4:	The Recovery Process	(A) Eight Pieces of Paper (B) Keys to Sobriety
Session 5:	Chemicals and the Personality	(A) Masks (B) How I See Myself/How Others See Me
Session 6:	Breaking the Behavioral Cycle	(A) Problem Solving Process (B) Stress Management
Session 7:	Attitudes: How Developed/How Changed	(A) Stinkin' Thinkin' (B) Changing Attitudes
Session 8:	Recovery: An Inside Job	(A) Higher Power Questionnaire (B) The Higher Power Within
Session 9:	Prevention of Relapse	(A) Planning Your Next Drunk/High (B) Symptoms of Relapse
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APPENDIX B2

M O D E L

FOR THERAPEUTIC EDUCATION FOR PATIENTS IN TREATMENT FOR ALCOHOLISM

1. Sober life is the primary direct goal and is to be continually reinforced.

*2. Basic requirements for achieving the goal of sober life generally are as follows:

   a. Recognition that one's alcohol use is causing major life problems.

   b. Understanding the extent of the alcohol problem and of one's denial mechanisms.

   c. Acceptance of abstinence as necessary for recovery.

   d. Formation of an action plan for maintaining sobriety.

3. Secondary indirect goals are as follows:

   a. Improved physical and mental functioning.

   b. Improved intimate life.

   c. Improved family life.

   d. Improved work life.

   e. Improved social life.

4. The achieving of the goal of sober life is complicated by the stress of every day living; therefore, this therapeutic program includes education in the nature of stress and how to cope with it.

---

*Note: Inherent in this program is acknowledgement of the validity of the FOUR ABSOLUTES:

   a. Recognition of reality is the beginning of HONESTY.

   b. Understanding ourselves and others frees us to LOVE.

   c. The deepest expression of acceptance is UNSELFISHNESS.

   d. The aim of a sobriety action plan is PURITY or simple commitment to an authentic spiritual life.

#R-1

IN-PATIENT TREATMENT PLAN

ORIENTATION PHASE

PROBLEM: Patient is unaware of the therapeutic process, program rules and components.

GOAL: Patient will become aware of the therapeutic process, program rules and components.

OBJECTIVES	FORMAT	RESOLUTION 1. Completed 2. Partially completed 3. Not completed		
1. Become aware of therapeutic process	Explanation of terms; detox, rehab, outpatient, aftercare, peer support (AA)	1	2	3
2. Become aware of program rules	Explanation of unit quidelines	1	2	3
3. Become aware of program components	Explanation of primary nursing, individual counseling, group therapy, sponsorship, family education and counseling, outpatient, aftercare and follow-up	1	2	3

PATIENT_____

COUNSELOR_____

D/C DATE_____

ØR-2

IN-PATIENT TREATMENT PLAN

ACTIVITIES CONTRACT

PROBLEM: Patient has developed an alcohol oriented life style.

GOAL: Patient will become involved in a structured sobriety oriented program by contract.

OBJECTIVES	CONTRACTED DATE	RESOLUTION 1. Completed 2. Partially completed 3. Not completed		
A. Prompt attendance at all scheduled activities: 1. Lectures & films 2. Group therapy 3. Individual counseling 4. Meals	A. As scheduled during Inpatient stay. Continuous.	1	2	3
B. Written	B. Written	1	2	3
C. Reading	C. Reading	1	2	3
D. Other	D. Other	1	2	3

PATIENT_____

COUNSELOR_____

D/C DATE_____

DISCHARGE SUMMARY AND PLAN

I. PROGRESS SUMMARY (to what extent have the goals or objectives of treatment been met?)

II. UPDATED PROBLEM STATEMENT (What remains to be done?)

III. STAFF RECOMMENDATIONS:

Treatment modality	Intensity	Time Frame (start/complete)	Accept/Reject
A. Outpatient treatment			
B. Aftercare			
C. A. A.			
D. Extended Inpatient care			
E. Intermediate Care facility			
F. Other (list):			

PATIENT_____

COUNSELOR_____

D/C DATE_____

RECOGNITION

PROBLEM: Patient does not recognize the role of alcohol and/or drug use in development of major life problems.

GOAL: Patient will recognize the role of alcohol and/or drug use in his/her major life problems and make a self-diagnosis.

OBJECTIVES	FORMAT	RESOLUTION 1. Completed 2. Partially completed 3. Not completed		
1. Recognize immediate crisis	1. Medical intervention and individual counseling	1	2	3
2. Recognize need for outside help to resolve the crisis	2. Medical intervention and individual counseling	1	2	3
3. Comply with help offered	3. Medical intervention and individual counseling	1	2	3
4. Recognize current crisis as part of a deteriorating pattern	4. Medical intervention and individual counseling	1	2	3
5. Recognize need for discovering underlying cause of this pattern	5. Individual counseling and group therapy	1	2	3
6. Recognize need for outside help in making this discovery	6. Individual counseling and group therapy	1	2	3
7. Comply with help offered	7. Individual counseling and group therapy	1	2	3
8. Recognize role of alcohol and/or drugs in major life problems and make self-diagnosis	8. Individual counseling and group therapy	1	2	3

PATIENT _____

COUNSELOR _____

D/C DATE _____

ØR-4

UNDERSTANDING

PROBLEM: Patient does not understand his/her use of a denial system to protect continued drinking.

GOAL: Patient will understand alcohol protective defense system and how to transfer defense energy to sobriety maintenance.

OBJECTIVES	FORMAT	RESOLUTION 1. Completed 2. Partially completed 3. Not completed		
1. Become aware of alcohol protective defense system e.g. rationalizing, minimizing, blame assigning, etc.	1. Individual counseling and group therapy	1	2	3
2. Understand defense system as necessary to continuance of drinking	2. Individual counseling and group therapy	1	2	3
3. Be able to identify preferred defenses in the past	3. Individual counseling and group therapy	1	2	3
4. Become open to feed back on current defenses	4. Individual counseling and group therapy	1	2	3
5. Understand that defenses are natural and necessary and that defense energy can be redirected	5. Individual counseling and group therapy	1	2	3
6. Begin to identify ways of redirecting defense energy to the goal of sober life e.g. reasoning, partializing, responsibility assigning, etc.	6. Individual counseling and group therapy	1	2	3

PATIENT_____

COUNSELOR_____

D/C DATE_____

ACCEPTANCE

PROBLEM: Patient has not accepted the disease of alcoholism and it's consequences as real, personal and immediate.

GOAL: Patient will accept the diagnosis of alcoholism and the need to begin a program of abstinence.

OBJECTIVES	FORMAT	RESOLUTION 1. Completed 2. Partially completed 3. Not completed
1. Recognize powerlessness and unmanageability as descriptive of the disease of alcoholism	1. Individual counseling and group therapy	1 2 3
2. Identify from personal experience indicators of powerlessness and unmanageability	2. Individual counseling and group therapy	1 2 3
3. Recognize the need for a power greater than ones self to aid in recovery	3. Individual counseling and group therapy	1 2 3
4. Choose a greater power that will be adequate for sustaining sobriety	4. Individual counseling and group therapy	1 2 3
5. Recognize the need for choosing BEST SELF over IMMEDIATE SELF	5. Individual counseling and group therapy	1 2 3
6. Make a conscious decision to follow BEST SELF	6. Individual counseling and group therapy	1 2 3

PATIENT_____

COUNSELOR_____

D/C DATE_____

#R-6

ACTION PLANNING

PROBLEM: Patient does not understand the sobriety planning process and does not have a sustaining structured sobriety plan.

GOAL: Patient will understand the change process and will develop a concrete action plan for sobriety maintenance.

OBJECTIVES	FORMAT	RESOLUTION 1. Completed 2. Partially completed 3. Not completed		
1. Understand recovery as a long term process	1. Individual counseling and group therapy	1	2	3
2. Understand the stages of the change planning process e.g. fantasy stage, indirect stage, direct stage	2. Individual counseling and group therapy	1	2	3
3. Identify which stage (emotionally) one is currently experiencing	3. Individual counseling and group therapy	1	2	3
4. Recognize resources available to help with recovery	4. Individual counseling and group therapy	1	2	3
5. Form a specific plan to make use of recovery resources using the "Guidelines for Recovery"	5. Individual counseling and group therapy	1	2	3

PATIENT_____

COUNSELOR_____

D/C DATE_____

WORK SHEET FOR STRESS - IDENTIFICATION AND MANAGEMENT

STRESSFUL SITUATION (Briefly describe)

ACCEPT

STRESSFUL FEELING(s) (List)

STRESS RESPONSE

Stress Recycling Thoughts

CHANGE

Stress Recycling Actions

STRESS MANAGEMENT

1) Recognize my stress recycling thoughts and actions.
2) Understand the stress managing thoughts and actions.
3) Accept the need for changing my thought and action patterns and work to overcome my resistance to change.
4) Develop an action plan for change and keep practicing it.

GAIN WISDOM

STRESS MANAGING THOUGHTS

STRESS MANAGING ACTIONS

Adapted from T. Gorski
by L. P. Smith- rev 6/82

STRESS RECYCLING ACTIONS	STRESS MANAGING ACTIONS
____Violence	____Temporary 'cooling off' period
____Arguing	____Honest expression of feelings following the rules for good communication; i.e. 1) Use "I" statements; 2) Do not prejudge others' responses; 3) Stay in the here and now; and 4) Practice open listening.
____Lying	
____Ignoring or running away from problems	____Do not make unnecessary life changes (changing jobs, moving, etc.) in the next 1 - 2 years. Plan necessary changes carefully
____Drinking	____Seek peer support (AA program)
____Taking mood altering drugs of any kind	____Proper diet and abstinence from alcohol and other drugs
	____Regular, moderate exercise
	____Relaxation techniques (deep breathing, meditation, etc.)
	____Creative or recreational activity
____Procrastinating	____Daily priority setting
____Other:	____Other:

STRESS RECYCLING THOUGHTS

____ "I demand or need love and approval."

____"I must be perfect."

____"You're bad!" "I'm bad!"

____"Ain't it awful!"

____"What if.....?"

____"I'm a victim of circumstances."

____"I'll run away."

____"I'm stuck with my past and will be scarred forever."

____"Things should be different."

____"I'll just drift along and maybe everything will work out."

STRESS MANAGING THOUGHTS

____"I will give love and good will."

____"I'm working for improvement, not perfection."

____"I will judge actions, not persons."

____"Good can come out of bad situations. I will look for the good."

____"I will take reasonable precautions and then 'let go & let God!"

____"I am responsible for the life I've been given."

____"I can cope."

____"I will live in the here and now."

____"I will 'act as if' God can be trusted. I will begin by accepting people and circumstances as they are."

____"God grant me the Serenity to accept the things I cannot change; the Courage to change the things I can; and the Wisdom to know the difference."

Adapted from A. Ellis
by L. P. Smith - Rev. 1/83

The basic model presented:

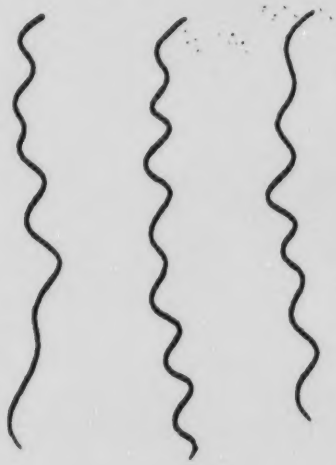
PROCESS _____ STRESS _____ GOALS _____

RECOGNITION

UNDERSTANDING

ACCEPTANCE

ACTION PLAN



PRIMARY (DIRECT):

_____ Sober life
(Best self)

SECONDARY (INDIRECT):

Improved _____

_____ Family Life

_____ Social Life

_____ Work Life

_____ Intimate Life

_____ Physical & Mental Life

KEY POINTS:

1. "Sobriety first" does not detract from the importance of other life concerns, but other life concerns (when made primary) detract from sobriety.

2. Daily commitment and cultivation are required.

3. Patients enter treatment or begin recovery because of pressure from one or more of the major life areas (such as job or family pressure). Denial of this fact retards progress as such denial assumes a level of control which no longer exists for the active alcoholic. Such denial may also result in denial of feelings such as resentment, self pity, guilt, etc!

4. Sobriety for one's own sake is an ideal to strive for and not a perfectly accomplished fact.

5. The clarifying of values and setting of priorities is an ongoing process.

SJWS 3055

L. P. Smith 6/82

CHECK LIST FOR WORKING THE PERSONHOOD SYSTEM

1. Simple (basic) Commitment
   - _____ Do I read from 24 hour book (or something similar) each day?
   - _____ Do I take time for prayer or reflection each day?
   - _____ Am I working the steps of A.A.?
   - _____ Is sober living primary to me?
   - _____ Do I attend A.A. regularly?

2. Reasoning
   - _____Have I made a list of reasons for staying sober?
   - _____Have I determined what the most important reason is?
   - _____Do I challenge my own thoughts for any continuing "stinkin' thinkin'"?

3. Partializing
   - _____ Am I focussing my energy on the "here and now" rather than the "there and then" or "if and when"?
   - _____ Am I practicing "One Day At A Time"?
   - _____ Am I setting priorities each day e.g. what is most important, next important, etc.?
   - _____ Do I practice deep breathing pauses as a means of keeping pace and perspective?

4. Recreation
   - _____ Am I taking time for regular exercise?
   - _____ Do I do anything purely for it's entertainment value?
   - _____ Have I tried any new activities?
   - _____ Do I take time for the fellowship part of A.A.?

5. Assigning Responsibility
   - _____ Do I understand my dependency needs and wishes?
   - _____ Do I accept my dependency needs and wishes?
   - _____ Do I negotiate my dependency needs and wishes with respect for others and at risk of rejection?
   - _____ Do I accept NO as well as YES from others without getting resentful?
   - _____ Do I say NO as well as YES to others without feeling guilty?
   - _____ Am I taking responsibility for my own sobriety program or subtly trying to make others responsible?
   - _____ Do I feel guilty because others are hurting even though I am not currently doing anything to cause it?
   - _____ Am I respecting the rights of others to live their own lives even though their actions may be in conflict with my own wishes?
   - _____ Have I given up pre-judging and reading other peoples' minds?

6. Cooperating (Trusting)
   - _____ Am I following the program as it unfolds for me each day?
   - _____ Am I practicing open listening?
   - _____ Do I really believe that others can help me?
   - _____ Am I taking Step 3?
   - _____ Do I use the Serenity Prayer?

7. Honest Communication of Feelings
   - _____ Do I acknowledge my feelings without making others responsible for them?
   - _____ Do I use "I statements" in expressing my feelings?
   - _____ Do I understand and express my "underneath" feelings, e.g. "I need you", "I'm afraid", "I hurt"?
   - _____ Do I have any "cooling off" techniques, e.g. take a walk, count to a hundred, take a few deep breaths, repeat the Serenity Prayer silently, etc.?

APPENDIX B3

C. Education

1. Specify plans for obtaining education you want or need to enrich your life (unless you have already done this in previous section):

2. What steps have you already taken? (check them off above).

Notes:

D. The Community

1. List changes you need to make in your relationship with your community, as a citizen participating in the community around you. Ex: Think about whether you have "dropped out", have a hostile relationship with the community, are isolated and lonely, would like to do something to be involved in a better community but think you can't...etc. Be sure to include any legal troubles.

2. Specify steps you plan (or have already begun) to take to begin the changes.

3. Give details of when, with whom, you plan to do these things. Include how these activities will fit into your daily, weekly, or monthly schedule. (Think about how you will arrange the time in relation to other priorities.)

Notes:

E. Activating old activities/developing new interests

1. List old activities you used to enjoy that you need to get back to; Also list new interests you wnt to develop.

2. Specify what you have already done, and what you plan to do about the above. (Have you needed to narrow down your choices?)

3. Give details about when, with whom, you will do these things, and how you have allowed for time in your life in relation to other priorities. Is expense and equipment involved? How will you finance it?

Notes:

APPENDIX B4

PROGRAM EVALUATION
COGNITIVE AND AFFECTIVE ASSESSMENT

Two objectives of the Molly Stark Hospital Alcoholism Unit are: 1) to increase the patient's knowledge of alcoholism as a disease and, 2) to improve the patient's self concept. These objectives are regarded as being cognitive and affective in nature respectively. To measure the effectiveness of the Alcoholism Unit's Program, an alcoholism quiz, cognitive scale, and a self evaluation rating scale, affective scale, are administered to each patient at the beginning and end of therapy, (prior to entering the rehabilitation program and immediately prior to discharge). For comparison purposes, group means are computed for each month and on an annual basis for each scale. Only scores of patients who complete treatment are included.

Data obtained are shown as follows:

MOLLY STARK HOSPITAL

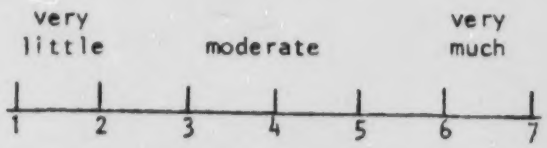
ALCOHOLISM UNIT

SELF-EVALUATION SCALE

NAME _____ DATE _____

DIRECTIONS: For each item below use the following scale to indicate what is true regarding your feeling at the present time. Select the most appropriate numerical value and write it in the space provided.

SCALE:



1. The degree to which I feel love towards others is _____.
2. The degree to which I feel loved by others is _____.
3. The degree to which I am honest with others is _____.
4. The degree to which I am able to control what happens to me is _____.
5. The degree to which I am free of resentment is _____.
6. The degree to which I am able to listen to others is _____
7. The degree to which I am able to avoid being critical of others is _____.
8. The degree to which I am free from irritation with others is _____.
9. The degree to which I am happy is _____.
10. The degree to which I am able to express myself orally to others is _____.
11. The degree to which I am free from fear and anxiety is _____.
12. The degree to which I feel free from guilt is _____.

MOLLY STARK HOSPITAL

ALCOHOLISM QUIZ

DIRECTIONS: PLEASE DO NOT WRITE ON THESE SHEETS. MARK YOUR ANSWERS ON THE ANSWER SHEET PROVIDED.

1. OF THOSE PEOPLE WHO DRINK ALCOHOL IN THE UNITED STATED APPROXIMATELY _____ BECOME ALCOHOLIC.
   - A. ONE PERSON IN THREE
   - B. ONE PERSON IN TWELVE
   - C. ONE PERSON IN TWENTY
   - D. ONE PERSON IN FORTY-FIVE
   - E. ONE PERSON IN ONE HUNDRED

2. A PERSON IS PROBABLY BEST REGARDED AS AN ALCOHOLIC IF HE:
   - A. DRINKS A QUART OF WHISKEY OR THE EQUIVALENT DAILY
   - B. HAS BEEN DRUNK THREE OR MORE TIMES IN HIS LIFETIME
   - C. DRINKS ALCOHOL TO THE EXTENT THAT IT CAUSES SERIOUS PROBLEMS IN SOME AREA OF HIS LIFE
   - D. DRINKS ALCOHOL TO THE EXTENT THAT HE LOSES HIS JOB, HOME, AND MARRIAGE, IF APPLICABLE

3. A PERSON CAN BECOME AN ALCOHOLIC BY DRINKING:
   - A. BEER ONLY
   - B. WINE ONLY
   - C. DISTILLED SPIRITS ONLY
   - D. BEER, WINE, AND DISTILLED SPIRITS
   - E. ALL OF THE ABOVE

4. INDIVIDUALS DRINK ALCOHOL TO:
   - A. REDUCE ANXIETY
   - B. PRODUCE EUPHORIA
   - C. GET OVER A HANGOVER
   - D. REDUCE WITHDRAWAL SYMPTOMS
   - E. ALL OF THE ABOVE

CONT'D

5. ALCOHOL IS A:

   A. STIMULANT

   B. DEPRESSANT

   C, STIMULANT IN SMALL QUANTITIES, BUT A DEPRESSANT IN LARGE QUANTITIES

   D. NONE OF THE ABOVE

6. THE RATIO OF MALE ALCOHOLICS TO FEMALE ALCOHOLICS IS ESTIMATED AS:

   A. 10 TO 1

   B. 8 TO 1

   C. 4 TO 1

   D. 1 TO 1

   E. 1 TO 5

7. WHAT PERCENTAGE OF THE ADULT POPULATION IN THE UNITED STATES IS ESTIMATED TO CONSUME ALCOHOL AT LEAST PERIODICALLY THROUGHOUT THEIR LIFETIME?

   A. 99%

   B. 95%

   C. 90%

   D. 70%

   E. 50%

8. THE MOST IMMEDIATE EFFECT OF ALCOHOL IS TO PRODUCE:

   A. "SLIPS OF THE TONGUE"

   B. POOR JUDGMENT

   C. LACK OF COORDINATION

   D. DIPLOPIA (SEEING DOUBLE)

   E. LOSS OF BLADDER CONTROL

9. THE IDEA THAT <u>CULTURAL</u> FACTORS MAY SERVE AS A BASIS FOR ALCOHOLISM IS ILLUSTRATED BY THE OBSERVATION THAT:

   A. CHINESE HAVE A LOWER FREQUENCY OF ALCOHOLISM THAN THE FRENCH

   B. STRAINS OF RATS HAVE BEEN RAISED THAT DEVELOP A PREFERENCE FOR ALCOHOL IN COMPARISON WITH WATER

   C. THE IRISH HAVE A LOW FREQUENCY OF OCCURRENCE OF ALCOHOLISM

   D. NONE OF THE ABOVE

CONT'D

10. THE IDEA THAT HEREDITARY FACTORS MAY SERVE AS A BASIS FOR ALCOHOLISM IS ILLUSTRATED BY THE OBSERVATION THAT:

    A. CHINESE HAVE A LOWER FREQUENCY OF ALCOHOLISM THAN THE FRENCH

    B. STRAINS OF RATS HAVE BEEN RAISED THAT DEVELOP A PREFERENCE FOR ALCOHOL IN COMPARISON WITH WATER

    C. THE IRISH HAVE A LOW FREQUENCY OF OCCURRENCE OF ALCOHOLISM

    D. ALL OF THE ABOVE

11. PROBABLY THE BEST VIEWPOINT IN REGARDING ALCOHOLICS IS THAT:

    A. ALCOHOLICS ARE ALL ALIKE

    B. ALCOHOLICS ARE ALL DIFFERENT

    C. ALCOHOLICS ARE DIFFERENT BUT THEY TEND TO HAVE SOME CHARACTERISTICS IN COMMON

    D. ALCOHOLICS ARE NO MORE ALIKE THAN INDIVIDUALS IN THE GENERAL POPULATION

12. THE MOST EFFECTIVE PROGRAM FOR TREATING ALCOHOLISM IS GENERALLY RECOGNIZED TO BE:

    A. CARE BY THE FAMILY PHYSICIAN

    B. A RELIGIOUS CONVERSION

    C. CARE BY A PSYCHIATRIST

    D. GROUP THERAPY BY A CLINICAL PSYCHOLOGIST

    E. ALCOHOLICS ANONYMOUS

13. INDIVIDUALS WHO ABSTAIN FROM DRINKING ALCOHOLIC BEVERAGES USUALLY DO SO:

    A. FOR MORAL OR ETHICAL REASONS

    B. BECAUSE THEY REACT ADVERSELY TO ALCOHOL

    C. BECAUSE THEY ARE ABSTAINING PROBLEM DRINKERS

    D. ALL OF THE ABOVE

14. SOCIAL DRINKERS ARE CLASSIFIED AS:

    A. INFREQUENT, FREQUENT, OR CONSTANT HEAVY DRINKERS

    B. MILD, MODERATE, SEVERE, OR PROFOUND DRINKERS

    C. CHRONIC OR ACUTE DRINKERS

    D. NONE OF THE ABOVE

CONT'D

15. ALCOHOLISM IS OFTEN DESCRIBED AS AN INSIDIOUS DISEASE BECAUSE:

A. IT APPEARS TO HAVE A HEREDITARY BASIS

B. ITS DEVELOPMENT OFTEN OCCURS OVER A 20 TO 30 YEAR PERIOD

C. THE CHANGES THAT TAKE PLACE IN AN INDIVIDUAL ARE OFTEN SMALL, GRADUAL, AND HARD TO DETECT

D. NONE OF THE ABOVE

16. THE CURRENT VIEWPOINT PERTAINING TO ALCOHOLISM IS THAT ARREST OF THE DISEASE IS ACCOMPLISHED:

A. ONLY BY TOTAL ABSTINENCE

B. BY LEARNING TO DRINK WITH CONTROL

C. ONLY IF THE UNDERLYING CAUSE IS IDENTIFIED

D. ONLY IF A PERSON HAS A RELIGIOUS EXPERIENCE

17. A "BENDER" IS A:

A. BLACKOUT

B. RESTAURANT IN CLEVELAND

C. PERIOD OF INCREASED DRINKING

D. HALLUCINATION

18. A CHRONIC DRINKER IS A PERSON:

A. WHO DRANK FROM AN EARLY AGE

B. WHO DRINKS USUALLY EVERY DAY

C. WHO IS CHARACTERIZED BY A VIOLENT TEMPER

D. WHO DRINKS ALONE

19. SUICIDE IS PROBABLY ATTEMPTED MORE FREQUENTLY BY ALCOHOLICS THAN THE GENERAL POPULATION BECAUSE:

A. ALCOHOLICS ARE UNCONSCIOUSLY ATTEMPTING TO DRINK THEMSELVES TO DEATH

B. ALCOHOLICS ARE TRYING TO GET HELP BY DRAWING ATTENTION TO THEMSELVES

C. ALCOHOLICS ARE TRYING TO "GET EVEN" WITH OTHER PEOPLE

D. THEY OFTEN FEEL TRAPPED IN THEIR DRINKING BEHAVIOR AND ARE TRYING TO SOLVE THEIR PROBLEM

CONT'D

20. THERE IS OFTEN A PROGRESSION TOWARDS WINE BY ALCOHOLICS BECAUSE:

A. THEY COME FROM ETHNIC BACKGROUNDS WHERE WINE IS DRUNK OFTEN

B. WINE IS HIGHLY ADVERTISED

C. WINE IS RELATIVELY "POTENT" AND INEXPENSIVE

D. THEY HAVE A TENDENCY TO PREFER THE TASTE OF WINE

21. ALCOHOLISM IS A _____ PROBLEM:

A. PHYSICAL

B. PSYCHOLOGICAL

C. SOCIAL

D. ALL OF THE ABOVE

22. THE CONSTANT HEAVY SOCIAL DRINKER DIFFERS FROM THE ALCOHOLIC INASMUCH AS:

A. THE CONSTANT HEAVY SOCIAL DRINKER OFTEN DRINKS PERIODICALLY, WHEREAS THE ALCOHOLIC DRINKS EVERY DAY

B. THE CONSTANT HEAVY SOCIAL DRINKER HAS CONTROL OF HIS DRINKING BUT THE ALCOHOLIC HAS LOST CONTROL

C. THE CONSTANT HEAVY SOCIAL DRINKER OFTEN DOES NOT HAVE SERIOUS PROBLEMS BECAUSE OF HIS DRINKING

D. THE ALCOHOLIC ENJOYS DRINKING MORE

23. THE IDEA THAT ALCOHOLISM IS PROGRESSIVE MEANS THAT:

A. ALCOHOLICS TEND TO HAVE LIBERAL IDEAS

B. DRINKING ALCOHOLIC BEVERAGES HAS BECOME POPULAR IN THE LAST 300 YEARS

C. THE DISEASE OF ALCOHOLISM BECOMES WORSE OVER TIME

D. ALL OF THE ABOVE

24. ALL OF THE FOLLOWING ARE TRUE REGARDING ALCOHOLISM <u>EXCEPT</u>:

A. THE AVERAGE AGE OF ALCOHOLICS HAS BEEN DECREASING WITH ALCOHOLICS OFTEN BEING IN THE 30'S, 20'S, AND EVEN TEEN YEARS

B. ALCOHOLICS OFTEN HAVE "GOOD" TOLERANCE TO ALCOHOL WHEN THEY START DRINKING

C. THERE IS NOW GENERALLY ACCEPTED EVIDENCE THAT SOME ALCOHOLICS CAN RETURN TO SOCIAL DRINKING AFTER INTENSIVE TRAINING

D. ALCOHOLICS ARE THOUGHT TO HAVE A PHYSIOLOGICAL OR PSYCHOLOGICAL VULNERABILITY TO ALCOHOL

CONT'D

25. ALL OF THE FOLLOWING ARE TRUE REGARDING THE CHRONIC ALCOHOLIC EXCEPT:

A. HE OFTEN HAS PERIODS OF TIME WITH LITTLE OR NO CRAVING FOR ALCOHOL

B. HE EXPERIENCES WITHDRAWAL SYMPTOMS IF HE STOPS DRINKING

C. HE IS USUALLY A DAILY DRINKER

D. HE OFTEN DOESN'T SHOW THE EFFECTS OF DRINKING MARKEDLY

26. ALL OF THE FOLLOWING ARE TRUE REGARDING THE ALCOHOLIC WHO IS A PERIODIC DRINKER EXCEPT:

A. HE HAS A STRONG CRAVING FOR ALCOHOL

B. HE MAY DRINK FOR DAYS, WEEKS, OR MONTHS

C. HE HAS PERIODS WITHOUT DRINKING WHICH ARE FREE FROM WITHDRAWAL SYMPTOMS

D. HE OFTEN FOOLS HIMSELF AND OTHERS REGARDING HIS ALCOHOLISM

27. THE "VICIOUS CYCLE" PERTAINING TO DRINKING ALCOHOL BY THE ALCOHOLIC REFERS TO THE FACT THAT:

A. THE ALCOHOLIC NEEDS MONEY TO DRINK BUT ALCOHOL KEEPS HIM FROM EARNING MONEY BY WORKING DRINKING

B. THE ALCOHOLIC HAS TO DRINK TO GET OVER THE EFFECTS OF DRINKING

C. AN EMOTIONAL PROBLEM DRIVES THE ALCOHOLIC TO DRINK BUT ALCOHOL MAKES THE PROBLEM WORSE

D. ALCOHOLICS TEND TO MARRY ALCOHOLICS AND HAVE CHILDREN WHO BECOME ALCOHOLIC

28. REJECTION AND ISOLATION BELONG TO WHICH OF THE FOLLOWING COMPONENT OF ALCOHOLISM:

A. PHYSICAL

B. PSYCHOLOGICAL

C. SOCIAL

D. NONE OF THE ABOVE

CONT'D

29. THE FREQUENT SOCIAL DRINKER:

A. IS THE LARGEST CATEGORY OF SOCIAL DRINKERS
B. OFTEN MAINTAINS A SUPPLY OF ALCOHOL IN THE HOME
C. SELDOM GETS DRUNK
D. DISAPPROVES OF THE FREQUENT DRUNK
E. ALL OF THE ABOVE

FOR ITEMS 30 TO 34 SELECT YOUR ANSWERS FROM THE FOLLOWING:

A. DOER
B. EXTREMIST
C. PERFECTIONIST
D. SENSE OF IMMEDIACY
E. IDEALIST

30. EVERYTHING MUST BE JUST RIGHT

31. HE DRIVES HIMSELF AND OTHERS

32. "IF A LITTLE BIT IS GOOD, A WHOLE LOT IS BETTER"

33. DO IT NOW

34. THERE ARE BEST CONDITIONS OR WAYS OF LIFE

35. A "BLACKOUT" RESULTING FROM THE CONSUMPTION OF ALCOHOL REFERS TO:

A. "PASSING OUT"
B. CONTINUING TO BEHAVE NORMALLY BUT LATER HAVING NO MEMORY OF EVENTS
C. REJECTION BY OTHERS
D. EXPERIENCING HALLUCINATIONS AND DELUSIONS

36. THE LOSS OF CONTROL PERTAINING TO ALCOHOLISM REFERS TO:

A. A PERSON WHO IS INTOXICATED AND DOESN'T KNOW WHAT HE IS DOING
B. THE EXCESSIVE SPENDING OF MONEY BY ALCOHOLICS
C. THE INABILITY TO LIMIT DRINKING
D. THE RAPID INCREASE IN ALCOHOLISM IN THE UNITED STATES

CONT'D

37. MARKED AGRESSION:

A. OCCURS MORE FREQUENTLY AS THE ALCOHOLIC PROGRESSES WITH HIS DRINKING

B. IS AN UNDERLYING PERSONALITY CHARACTERISTIC OF ALL ALCOHOLICS

C. OCCURS RARELY IN ALCOHOLICS

D. ALL OF THE ABOVE

38. THE EMOTIONS THAT ARE OFTEN CHARACTERISTIC OF THE ALCOHOLIC ARE:

A. COMPASSION AND SORROW

B. ANGER AND FEAR

C. RESENTMENT AND SELF-PITY

D. LOVE AND HUMILITY

39. THE "GEOGRAPHIC ESCAPE"

A. REFERS TO THE TENDENCY OF INDIVIDUALS TO RELOCATE THEMSELVES GEOGRAPHICALLY TO SOLVE PROBLEMS

B. OFTEN DOES NOT SOLVE THE PROBLEMS

C. MAY HELP AN INDIVIDUAL SOMETIMES BUT USUALLY DOES NOT

D. ALL OF THE ABOVE

40. THE MORNING DRINK:

A. IS A DRINK OF ALCOHOL TAKEN AFTER SOMEONE'S DEATH

B. IS TAKEN TO RELIEVE A "HANGOVER"

C. HAS A TENDENCY TO LOSE ITS EFFECTIVENESS WITH REPETITION

D. BOTH (B) AND (C) ABOVE

41. "BENDERS" OCCUR:

A. USUALLY ON WEEKDAYS

B. IN THE EVENING

C. OFTEN ON WEEKENDS, HOLIDAYS, AND VACATIONS

D. NONE OF THE ABOVE

42. "PROTECTING THE SUPPLY" OF ALCOHOL:

A. IS CHARACTERISTIC ONLY OF ALCOHOLICS WHO ARE FINANCIALLY POOR

B. IS CHARACTERISTIC OF MOST ALCOHOLICS

C. IS CHARACTERISTIC OF THE SEVERE ALCOHOLIC ONLY

D. REFERS TO THE PROMOTION OF ALCOHOL CONSUMPTION BY THE PRODUCERS OF ALCOHOL

CONT'D

43. ALCOHOLISM TENDS TO BE FOUND MOST OFTEN:

A. AMONG INDIVIDUALS OF LOW INTELLIGENCE

B. AMONG INDIVIDUALS OF VERY HIGH INTELLIGENCE

C. AMONG INDIVIDUALS WHO DO PHYSICAL WORK

D. AMONG INDIVIDUALS REGARDLESS OF JOB, EDUCATION, OR LEVEL OF INTELLIGENCE

44. INDIVIDUALS ARE OFTEN THOUGHT TO LOSE DIFFERENT TYPES OF HEALTH AS THEY PROGRESS WITH ALCOHOLISM. WHICH OF THE FOLLOWING BEST ILLUSTRATES THE SEQUENCE IN WHICH THE LOSS OF THE TYPES OF HEALTH OCCURS?

A. PHYSICAL HEALTH, PSYCHOLOGICAL HEALTH, SPIRITUAL HEALTH

B. PSYCHOLOGICAL HEALTH, SPIRITUAL HEALTH, PHYSICAL HEALTH

C. SPIRITUAL HEALTH, PSYCHOLOGICAL HEALTH, PHYSICAL HEALTH

D. PSYCHOLOGICAL HEALTH, SPIRITUAL HEALTH, PHYSICAL HEALTH

45. THE FOUR ABSOLUTES WHICH ARE OFTEN ADVOCATED IN ALCOHOLICS ANONYMOUS ARE:

A. LOVE, HONESTY, PURITY, UNSELFISHNESS

B. LOVE, HONESTY, HUMILITY, UNSELFISHNESS

C. LOVE, HONESTY, HAPPINESS, HUMILITY

D. LOVE, KINDNESS, HAPPINESS, HUMILITY

46. THE MOTIVATION TO STOP DRINKING:

A. OFTEN OCCURS AFTER A CRISIS OR A SERIES OF CRISES FOR AN INDIVIDUAL

B. OFTEN OCCURS WHEN AN INDIVIDUAL HAS THE EXPERIENCE OF SURRENDERING IN HIS STRUGGLE WITH ALCOHOL

C. OFTEN SEEMS TO OCCUR WHEN A PERSON "HITS HIS BOTTOM"

D. ALL OF THE ABOVE

47. ALCOHOLISM IS REGARDED AS AN ILLNESS BECAUSE:

A. IT HAS DEFINABLE CHARACTERISTICS

B. IT IS INCAPACITATING

C. IT IS PROGRESSIVE

D. ALL OF THE ABOVE

CONT'D

48. COUNSELING IS REGARDED AS BEING BENEFICIAL TO ALCOHOLICS BECAUSE:

A. THE ALCOHOLIC NEEDS COUNSELING

B. THE COUNSELOR KNOWS THE ANSWERS

C. THE ALCOHOLIC HAS AN OPPORTUNITY TO CLARIFY HIS THINKING

D. NONE OF THE ABOVE

49. ECONOMIC PROGRESS OFTEN OCCURS FOR THE SOBER ALCOHOLIC BECAUSE:

A. HE STOPS SPENDING MONEY FOR ALCOHOL

B. HE OFTEN IS ABLE TO GET A JOB IF HE DOESN'T HAVE ONE

C. HE OFTEN IS A PERSON OF ABOVE AVERAGE ABILITY AND FREQUENTLY OBTAINS PROMOTIONS AND RAISES

D. ALL OF THE ABOVE

50. ALCOHOLISM IS PROBABLY BEST REGARDED AS:

A. AN ILLNESS WITH NO EFFECTIVE TREATMENT

B. A FORM OF MORAL DERELICTION

C. A TREATABLE ILLNESS

D. A FORM OF PHYSICAL AND PSYCHOLOGICAL WEAKNESS

ALCOHOLISM UNIT PROCEDURE

Title: Rehabilitation Counseling Goals and Objectives

Goals

1) For the patient to decide whether he/she is alcoholic or not.
   Objectives
   a. To discuss problems related to his/her alcohol use.
   b. To gain knowledge regarding alcoholism.
   c. To gain an understanding of his/her usage of alcohol.

2) For the patient to gain knowledge regarding the disease of alcoholism.
   Objectives
   a. To attend lectures on alcoholism.
   b. To read literature on alcoholism.

3) For the patient to start a program of recovery from alcoholism within the alcohol unit.
   Objectives
   a. To tell his story.
   b. To take part in reading groups.
   c. To complete Steps 1-3 of the Alcoholics Anonymous Program and Steps 4 and 5 as appropriate.

4) For the patient to take part in positive growth experiences within the alcoholism unit as a step towards adopting a more satisfying life style.
   Objectives
   a. To discuss personal problems with the goal of gaining self understanding and acceptance.
   b. To experience desensitization.
   c. To establish life goals.
   d. To clarify values.

5) For the patient to make a satisfactory adjustment in the community upon his/her release from the alcoholism unit.
   Objectives
   a. To obtain AA contact.
   b. To plan for the attainment of educational and vocational goals.
   c. To improve family relationships.

APPENDIX B5

FIGURE I

The Feeling Chart

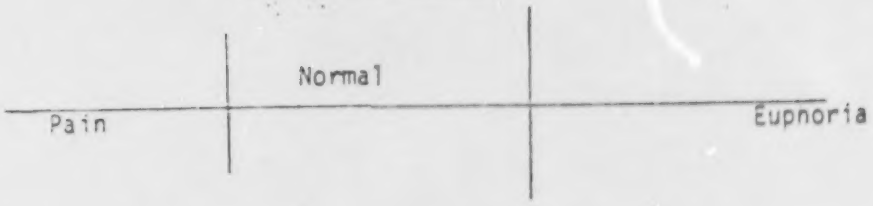


FIGURE II

Phase One: Learns Mood Swing

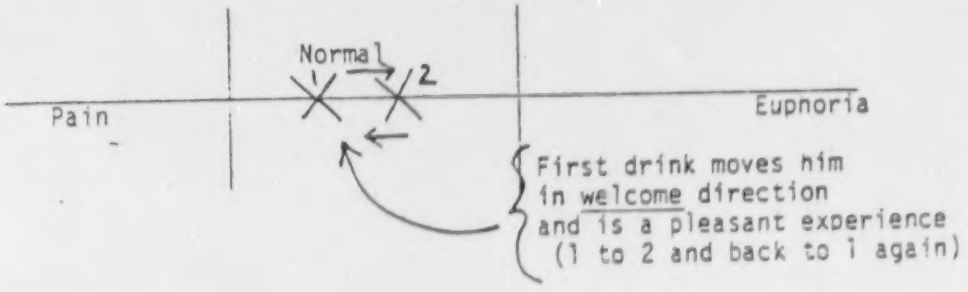


FIGURE III

Phase Three: Harmful Dependence

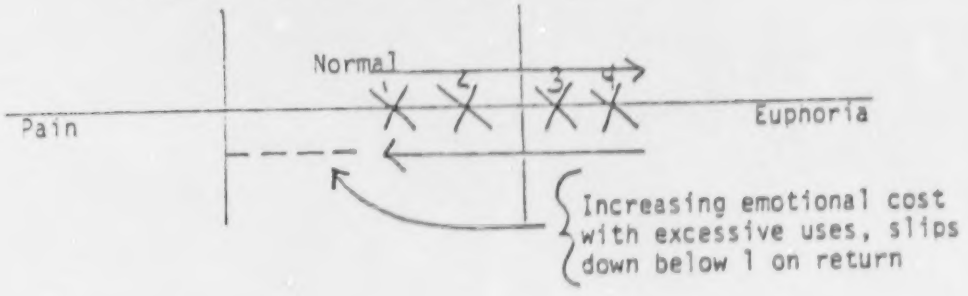


FIGURE IV

Phase Three: Harmful Dependence

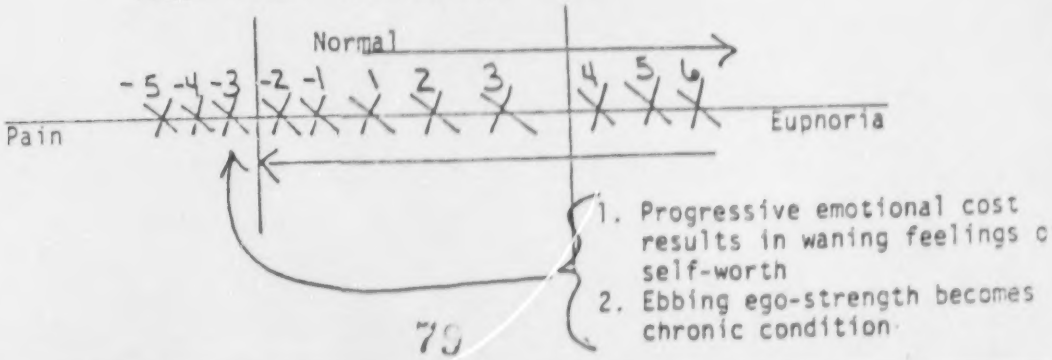


FIGURE V

Phase Three: Harmful Dependence

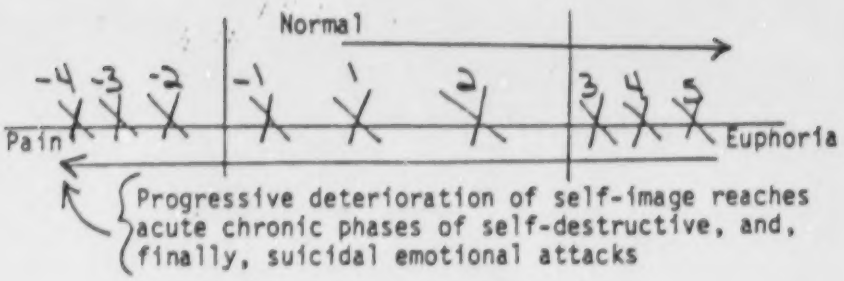
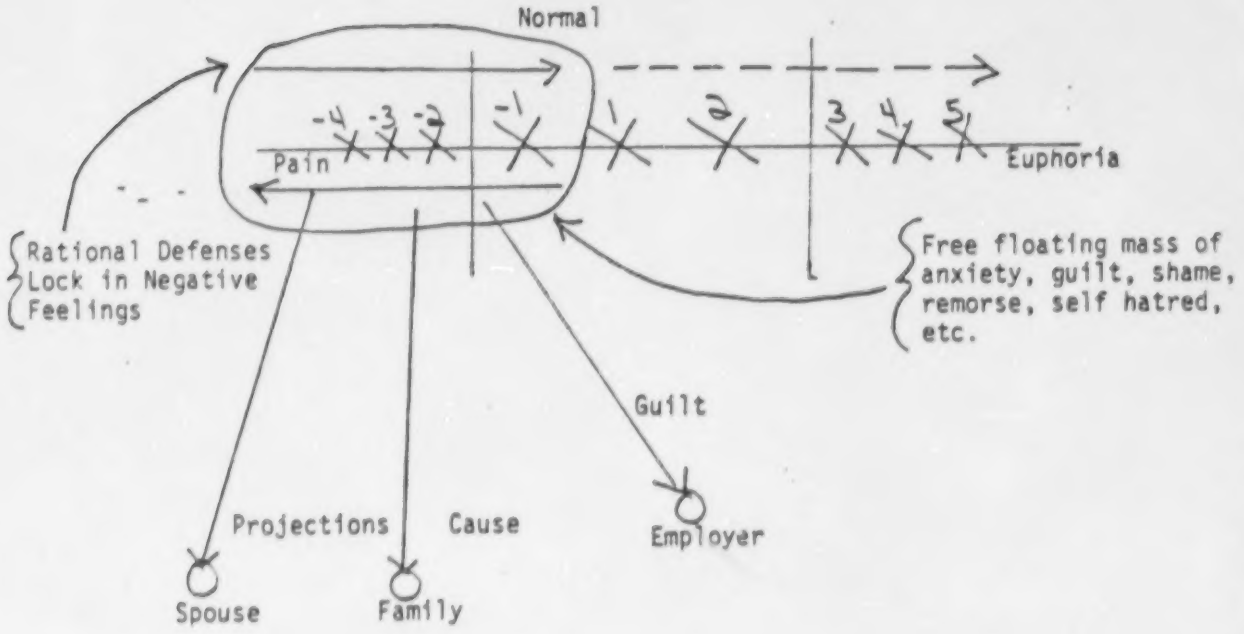

Normal
-4 -3 -2 -1 1 2 3 4 5
Pain
Euphoria
Progressive deterioration of self-image reaches acute chronic phases of self-destructive, and, finally, suicidal emotional attacks

FIGURE VI

Phase Four: Drinks to Feel Normal

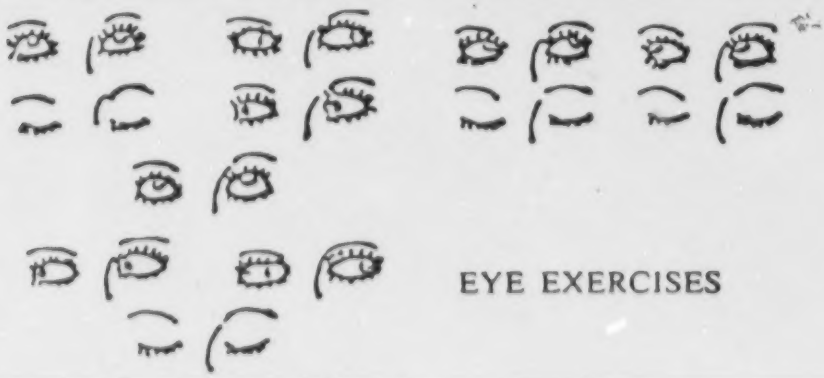
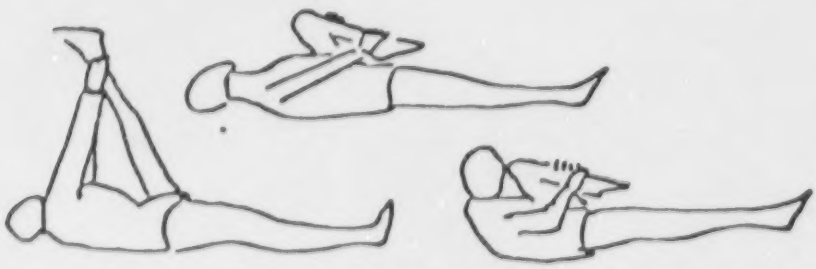


Johari Window

MYSELF

OTHERS		
	1 OPEN	2 SECRET
	3 BLIND	4 SUBCONSCIOUS

Exercise Time: 10 Minutes

	BENEFITS
PERFECT POSTURE	Develops flexibility in hips, knees and ankles; frees legs and weight of body from muscular tension; has calming effect on nervous system.
ALTERNATE BREATHING	Cleanses nasal passages; calms the mind; especially helpful in preventing buildup of tension; helps to relieve sinus headache.
 EYE EXERCISES	Reduces fatigue and eyestrain; strengthens optic nerves and muscles.
 DANCE OF THE LEGS	Firms abdomen, buttocks, and thighs; all-around toning and limbering exercise.

HOMEWORK ASSIGNMENT SCHEDULE

Please complete or work on each of the assignments listed below by their appropriate date in the Program. Homework and reading assignments are to help you gain the maximum benefit from the Program. These assignments are expectations and your responsibility to complete.

*** Read pages 39 - 45 (Group Therapy) in Gray Booklet when starting the Program. Also read the 24 Hour Book each day.

FIRST WEEK:

For:

1. Monday ---- Illness Concept -- Big Book, "Doctors Opinion," pg. xxxiii, Chapter 2 - pages 17 - 29
2. Tuesday ---- "I'll Quit Tomorrow" -- Gray Folder, pages 1 - 5; 13 - 17 and page 68.
3. Wednesday -- Medical Aspects -- Gray Booklet, pages 18 - 24.
4. Thursday --- Problem Solving -- Gray Booklet, pages 43 - 46, 61 and 82
5. Friday ----- Medication -- Gray Booklet, pages 23 - 24, 54 - 60

SECOND WEEK:

For:

1. Monday ---- Steps 1, 2 and 3 -- Chapter 2, pages 19 (We have concluded....) - 24 (end of italics); Chapter 3, pages 30 - 43; Chapter 5, pages 58 - 63 (bottom of page) Page 570 - quotation Herbert Spencer Pamphlet - Alcoholism & A.A. Program
2. Tuesday ---- Phases of Alcoholism/Chemical Dependency -- Gray Booklet, pages 6 - 12.
3. Wednesday -- Addictive Thinking -- Big Book, pages 30 - 43, Gray Folder 36 - 37
4. Thursday --- About Sex -- Big Book, page 68 (last paragraph) to page 69 (...to be despised and loathed)
5. Friday -- Nutrition -- Gray Booklet, pages 66 - 67

THIRD WEEK:

For:

1. Monday ----- Tools -- Gray Folder, pages 54 - 60; 70 - 72; and 75 - 78, and Big Book, pages 17 - 29
2. Tuesday ---- Alcoholism in the Family -- Gray Booklet, pages 25 - 28; Big Book, pages 104 - 121

1. WHAT DOES A.A. MEAN TO YOU IN CONTINUING YOUR RECOVERY?

2. EXPLAIN: A DRY DRUNK - AND DO YOU THINK YOU WILL BE AFFECTED BY ONE.

3. ON A SCALE OF 1 TO 5, WHAT DO YOU THINK YOUR CHANCES ARE OF REMAINING SOBER? WHY?

RESOURCES

BOOKS

A. Treatment and Rehabilitation of the Chronic Alcoholic. B.Kissin and H. Begleiter(Eds)
New York: Plenum Press, 1977

B. The Substance Abuse Problems. S.Cohen
New York: The Hawthorn Press, 1981

C. Marty Mann's New Primer on Alcoholism. M.Mann
New York: Holt, Rinehart and Winston, 1981

D. Marty Mann Answers Your Questions About Drinking and Alcoholism. M. Mann
New York: Holt, Rinehart and Winston, 1970

E. Loosening the Grip. J.Kinney and G. Leaton
Saint Louis: The C.V. Mosby Company, 1978

F. Structured Experiences for Human Relations Training. W.Pfeiffer and J.Jones (Eds.)
La Jolla, California: University Associates, 1974

G. Youth, Alcohol, and Social Policy. H. Blane and M.Chafetz (Eds.)
New York: Plenum Press, 1979

H. Alcohol & Alcoholism: Problems, Programs, & Progress. National Institute of Mental Health
National Institute on Alcohol Abuse and Alcoholism. DHEW Publication No. (HSM) 72-9127
Revised 1972

I. The Alcoholisms: Detection, Assessment, and Diagnosis. G.Jacobson
New York: Plenum Press, 1977

J. Alcoholism and Drug Dependence: A Multidisciplinary Approach. J.Madden, R.Walker and W.Kenyon (Eds.)
New York: Plenum Press, 1977

K. On Becoming a Person: A Therapist's View of Psychotherapy. C.R. Rogers
Boston: Hoghhton Mifflin Company, 1961

RESOURCES

BOOKS

L. Communicative Speaking and Listening. R.Oliver, H.Zelko, and P.Holtzman
New York: Holt, Rinehart and Winston, Inc., 1968

M. Alcoholism: Treatable Illness. J.G. Strachan
Vancouver: Mitchell Press Limited

N. A Guide to Addiction and its Treatment. M.Glatt
New York: John Wiley & Sons, Inc., 1974

O. Alcoholics Anonymous.
New York City: Alcoholics Anonymous World Services, Inc., 1976

P. Recovery of Reality.G.Mann
New York: Harper and Row, 1979

Q. Self Esteem: A Family Affair. J.I.Clark
New York: Winston Press, 1978

R. Drugs From A to Z. R.R. Lingeman
New York: McGraw Hill, 1974

S. Licit and Illicit Drugs. E.Brecher
Boston: Little, Brown and Co., 1972

T. A New Guide to Rational Living. A.A. Ellis and R.A. Harper
Holywood: Wilshire Book Co., 1975

PAMPHLETS

AA. Why Haven't I Been Able To Help? Johnson Institute

BB. Intervention: A Turning Point for the Alcoholic. Johnson Institute

CC. Alcoholism: A Treatable Disease. Johnson Institute

RESOURCES

PAMPHLETS

DD. Detachment. Johnson Institute

EE. The Dynamics of Addiction. Johnson Institute

FF. Chemical Dependency & Recovery are a Family Affair. JOHNSON Institute

GG. Making Choices: How Alcohol and Other Drugs Can Affect Your Life. Johnson Institute

HH. Some Perspectives on Alcoholism. Johnson Institute

II. Women, Alcohol and Dependency.Johnson Institute

JJ. Blackouts and Alcoholism. Johnson Institute

KK. Medical Consequences of Alcoholism. Johnson Institute

LL. Perspectives on Treatment. Hazelden

MM. Is Pessimism About Alcoholics Justified? Hazelden

NN. Recovery for the Whole Family. Hazelden

OO. Professional Education # 2 Diagnosis: Alcoholic. Hazelden

PP. Step 4: An Adventure in Self-Discovery. Hazelden

QQ. Professional Education # 3 Early Clues for Diagnosing Alcoholism. Hazelden

RR. Step One: The Foundation of Recovery. Hazelden

SS. Alcoholism: A Merry-go-round Named Denial. Hazelden

TT. Guide for the Family of the Alcoholic. Kemper Group

UU. A Guide to the Twelve Steps of Alcoholics Anonymous. A.A. of Akron

RESOURCES

PAMPHLETS

VV. The Four Absolutes. Alcoholics Anonymous

WW. Acceptance: The Way to Serenity and Peace of Mind. Abbey Press

XX. Free to Care. Hazelden

YY. A Look at Relapse. Hazelden

JOURNALS

1. Alcoholism
2. Alcohol Health and Research World.
3. The A.A. Grapevine

FILMS

1A. "Medical Aspects of Alcoholism" (2 reels) 30 minutes each

2A. "I'll Quit Tomorrow" (2 reels) Parts 1,2,3 30 minutes each

3A. "Alcohol, Drugs, or Alternatives" 30 minutes

4A. "Alcoholism and the Family" (Fr. Martin) 42 minutes

5A. "Life, Death and Recovery of an Alcoholic" (Dr. Pruach) 25 minutes

6A. "Chalk Talk" (revised) 45 minutes

7A. "Alcohol, Drugs: The First Step--A Way Out" 20 minutes

8A. "They Do Recover" 22 minutes

APPENDIX B8

LAKELAND INSTITUTE

PATIENT EVALUATION FORM

In order for staff to be able to assess our program and implement changes that may be helpful to future individuals entering chemical dependency treatment, we need your help. Having now completed a twenty-eight day rehabilitation program, we would appreciate your filling out this Program Evaluation Form as honestly and completely as possible. Please know that your recommendations will definitely be considered in the future planning of the program. Thanks for your help.

Please give your impression of the following areas of the program, by circling a number from one to ten on each scale with one being poor, four being fair, seven being good and ten being excellent. Then please list any specific thoughts or feelings for each of these areas and what suggestions do you have for improvements or changes.

(1) The education about alcoholism including all films, lectures, discussions.

1 2 3 4 5 6 7 8 9 10
Poor Fair Good Excellent

(2) The group therapy sessions.

1 2 3 4 5 6 7 8 9 10
Poor Fair Good Excellent

(3) Family Day activities.

1 2 3 4 5 6 7 8 9 10
Poor Fair Good Excellent

(4) Family or Couple's Meetings.

1 2 3 4 5 6 7 8 9 10
Poor Fair Good Excellent

APPENDIX B9

Check the most appropriate responses:

1. An alcoholic who continues to drink alcohol will get progressively worse.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

2. One can do nothing to help the problem drinker.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

3. The problem drinker must ask for help before he/she can be helped.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

4. Alcoholism is a progressive illness.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

5. My spouse's job is the reason he/she drinks.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

6. It is my duty to live with my spouse no matter what happens.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

7. My spouse does not love me or the family when he/she is drinking.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

8. My spouse's inability to obtain more education and/or training is the reason he/she drinks.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

9. We would have a good marraige if my spouse did not drink.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

10. I am unable to make plans and/or decisions relative to our family's life.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

11. My spouse would not drink as much if I was a better wife/husband.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

12. I neither deserve nor contribute in any way to the verbal and/or physical abuse I have received from my spouse.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

13. Methods have not worked yet to stop my spouse from drinking.

Agree ____ Moderately Agree ____ Moderately Disagree ____ Disagree ____

14. If my spouse really cared about his/her family, he/she would quit drinking.

Agree	Moderately Agree	Moderately Disagree	Disagree

15. If our sexual life were improved my spouse would not drink as much.

Agree	Moderately Agree	Moderately Disagree	Disagree

Check the appropriate responses:

In the past three weeks, have you:

		YES	NO
1.	Poured out your spouse's liquor?	___	___
2.	Concealed from other people the seriousness of your spouse's drinking?	___	___
3.	Phoned your spouse's employer to report sickness or tardiness as a result of drinking?	___	___
4.	Ridden in a car with your spouse driving after he/she had been drinking (heavily)?	___	___
5.	Lost control while speaking with your spouse about his/her drinking behavior?	___	___
6.	Been afraid to discuss the drinking problem with your spouse?	___	___
7.	Informed your spouse that you are seeking counseling for your (his/her) drinking problem?	___	___
8.	Initiated conversations about alcohol or problem drinking with your spouse?	___	___
9.	Spent time reading for pleasure and/or self-improvement?	___	___
10.	Talked to your children about their mother's/father's drinking problem?	___	___
11.	Talked to your spouse's family about his/her drinking problem?	___	___
12.	Talked to your family about your spouse's drinking problem?	___	___
13.	Been able to express your true feelings to your spouse with regards regards to any situation within your home?	___	___
14.	Cancelled plans or engagements because your spouse was drinking?	___	___
15.	Felt there is hope for your husband/wife and your marriage?	___	___
16.	Been talking with a third party about your spouse's drinking?	___	___
17.	Felt guilty about your contributing to your spouse's drinking?	___	___
18.	Thought about separation?	___	___
19.	Thought about divorce?	___	___
20.	Thought about marriage counseling?	___	___
21.	Noticed that your husband/wife is drinking more, less, or the same? (Circle One)		

Place a checkmark on the following scales at whatever point you feel best describes your spouse.

Insensitive	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Sensitive
Dishonest	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Honest
Irresponsible	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Responsible
Unlovable	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Lovable
Cruel	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Kind
Stupid	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Intelligent
Unattractive	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Attractive

Place a checkmark on the following scales at whatever point you feel best describes yourself.

Inactive	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Active
Unattractive	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Attractive
Unlovable	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Lovable
Nervous	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Calm
Irresponsible	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Responsible
Selfish	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Unselfish
Indecisive	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Decisive
Stupid	___ 1	___ 2	___ 3	___ 4	___ 5	___ 6	Intelligent

REFERENCES

Davis, R.E. The primary prevention of alcohol problems. Alcohol Health and Research World, 1976, 2 (3), 10-12.

Engs, R.C. and Mulhall, P.F. Again - let's look before we leap: the effects of physical activity on smoking and drinking patterns. Journal of Alcohol and Drug Education, 1981, 26 (2), 65-74.

Leukefeld, C.G. They do meet - an analysis of prevention and treatment. 33rd Annual Meeting of the Alcohol and Drug Problems Association of North America, Washington, D.C., August, 1982.

Milgram, C.G. A descriptive analysis of alcohol education materials. Journal of Studies on Alcohol. 1980, 41 (11), 1209-1216.